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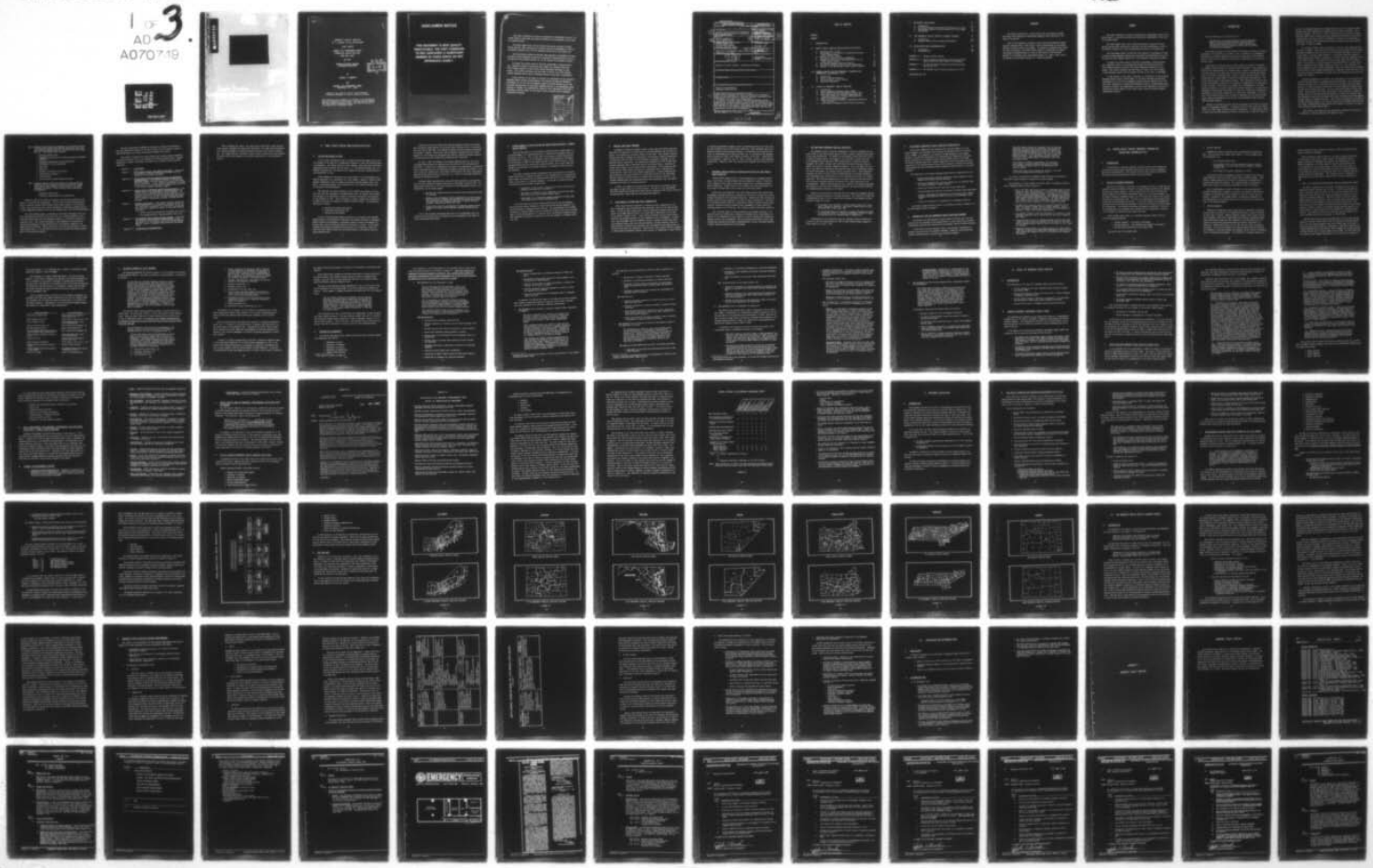

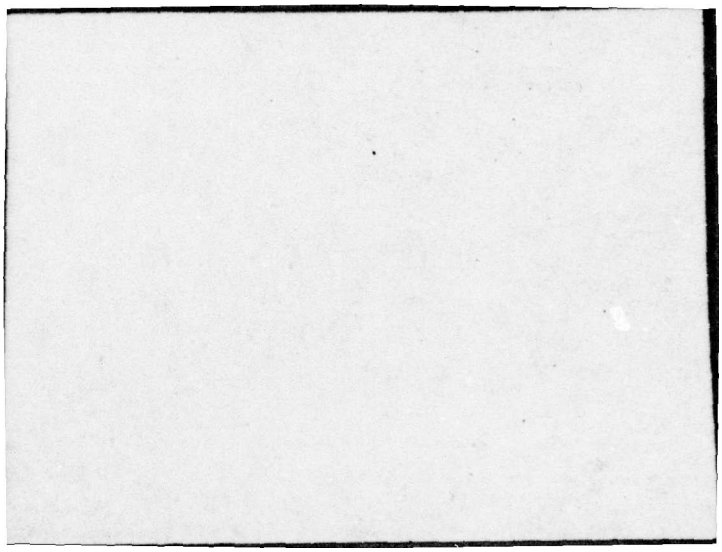

EMERGENCY HEALTH SERVICES IN A NUCLEAR ATTACK ENVIRONMENT

FINAL REPORT

DEFENSE CIVIL PREPAREDNESS AGENCY
CONTRACT NO. DCPA-01-78-C-0210
WORK UNIT 2422G

MAY 1979

BY

CHARLES G. ANDERSON

FOR

DEFENSE CIVIL PREPAREDNESS AGENCY
WASHINGTON, D.C. 20301

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SUMMARY

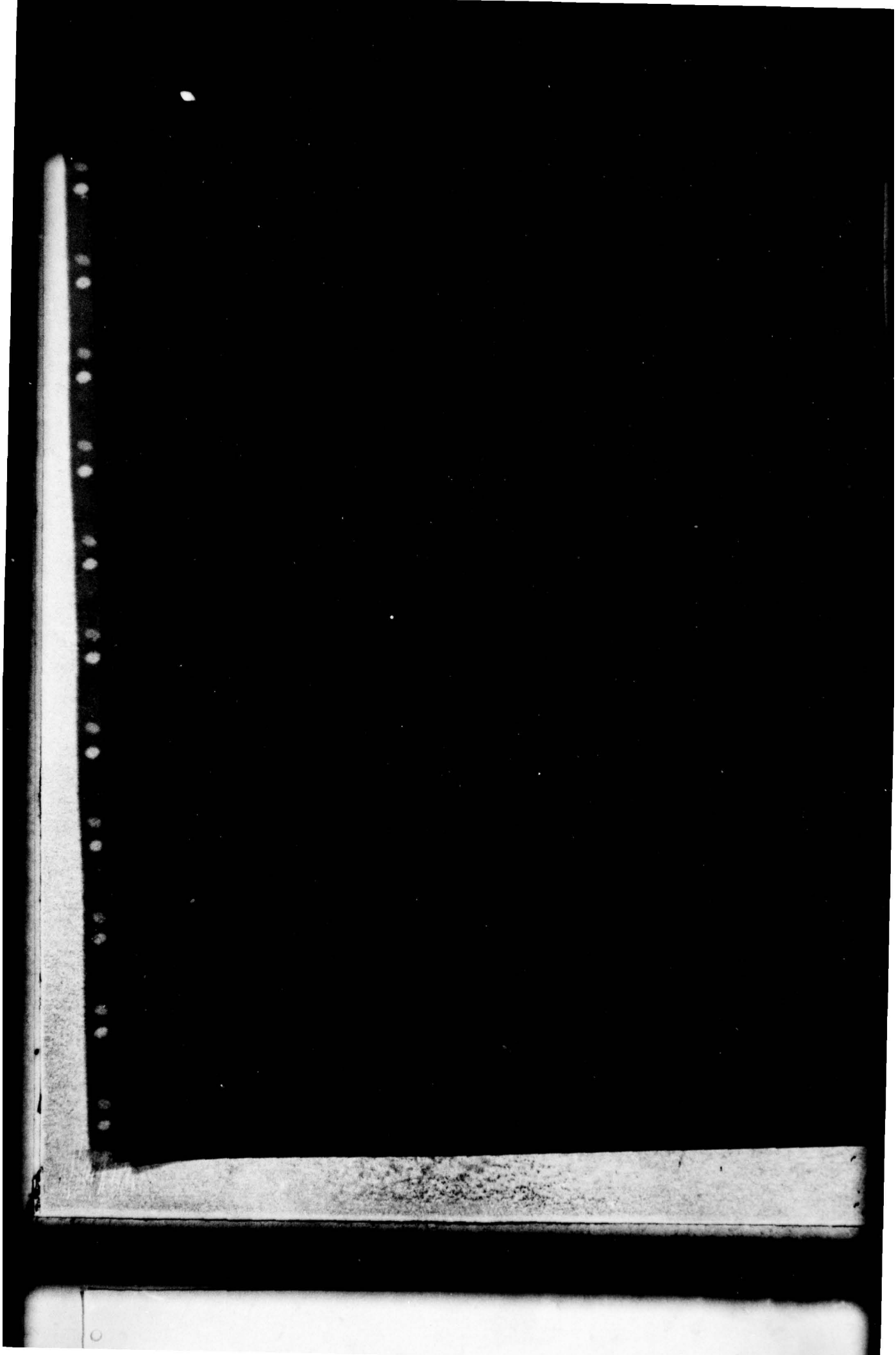
This report addresses the issues surrounding the preparedness status of the United States to cope with the health and medical care requirements in the event of a nuclear attack.

The report begins with a fairly detailed historical overview of Public Health Service's (PHS) mobilization activities from the establishment in 1955 of the medical stockpile up to the few remaining activities of the present day.

The relationship between the PHS and other agencies of government in terms of health related emergency planning and operational responsibilities as well as the specific Civil Defense related role of the military is discussed in detail.

To assess the current status of National preparedness, System Sciences, Inc. conducted a series of interviews with Federal and regional health and Civil Defense planners as well as with health department personnel in five states. The overall conclusion was that there is little or no Civil Defense related emergency health service planning activity at any level of government.

A major portion of the report is devoted to a description of the potential Emergency Health Service related impact of the Health Planning and Resources Development Act of 1974 and the Emergency Medical Services Systems Act of 1973. With minor modification in operational emphasis and with a correspondingly minor increase in funding, the organizations created by this legislation could have a significant positive impact on the overall issue of health related emergency preparedness planning.



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FOREWORD

This report considers the current status and the potential problems associated with planning and implementing Emergency Health Services in the event of nuclear war.

Much of the information presented in this report was generated through personal interviews with a wide range of health professionals at the Federal, Regional and State levels of government. In addition to thanking these people for their cooperation, the author further wishes to acknowledge the support and guidance provided during the course of this effort by the Technical Monitor for the Defense Civil Preparedness Agency, Mr. James W. Kerr, and by the members of the System Sciences, Inc. staff who assisted.

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I. INTRODUCTION

The work objective of this project was to:

> "Ascertain the most effective means of relating Emergency Medical Services and Health Resource Administration to Nuclear Crisis Planning in order to assure the efficient functioning of health, medical and safety resources during a nuclear attack emergency."

Addressing the issues of effectiveness and efficiency requires an in-depth assessment of the situation as it exists. Thus, in addition to recommending a new approach this report presents an overview of recent and current planning efforts to cope with the health and medical care requirements in the event of a nuclear attack.

Historically, there have been two major schools of thought in reference to emergency health services in a nuclear attack environment. One position has been that the problem would be so enormous that no amount of planning would have an impact and thus only token time and resources should be expended developing plans to perform an impossible task. This is a fairly extreme position, held incidentally by a large number of disaster-oriented health professionals. The second position goes to the opposite extreme. Those holding this position tend to view the potential situation as an extension or augmentation of normal operational procedures. This results in planning for the management of the "Mass Casualty Situation" in terms of large-scale natural disasters or in terms of the management of battlefield casualties on a large scale without due consideration being given to the likely constraints of a nuclear war environment. This concept is not realistic and in fact is largely responsible for the lack of credibility usually associated with nuclear war related Emergency Health Services (EHS) planning documents.

Neither of the above positions should be accepted as the basis for overall medical countermeasure planning. A nuclear attack situation could very likely result in a wide range of medical response requirements. In some areas it would be quite true that the devastation would be so great that to think in terms of

any sort of organized medical care response would be out of the question simply because there would essentially be nothing left with which to respond. This situation however, even in the largest of attacks, would be far from universal. Obviously there would be large rural areas essentially unaffected by the direct weapons effects and there could be, depending on a variety of circumstances, a substantial portion of the United States urban environment which would sustain only slight to moderate damage.

It is highly unlikely that a nuclear war on the U.S. would begin with absolutely no warning. There would most likely be a certain amount of "detectable" increased readiness activity on the part of the Federal government prior to an actual attack. The most likely prelude to a nuclear war would be a period of rising international tension, culminating in a crisis situation immediately prior to a nuclear conflict. This period of crisis buildup might vary from days to weeks. In any event, it is quite probable that there would be at least several days of awareness of the imminent danger of nuclear war. This potential pre-attack awareness period is highly significant since, with proper advance planning at all levels of Civil Defense responsibility, communities could carry out a variety of pre-attack countermeasure programs that would substantially increase the chances for survival.

Rational management of the medical care requirements of the surviving population would also require coordinated pre-attack planning. This planning process must consider that a credible EHS plan should recognize that the primary thrust is to control resources rather than to provide immediate emergency medical care to the injured survivors. This is a basic point which is often overlooked. While casualty care could be provided in some situations, clearly the primary function of an operational EHS system is to control and conserve medical resources to such time post-attack that their utilization would have maximum positive impact on long-term survival. This concept is essentially the reverse of what is usually thought of in terms of health related Emergency Services, and this leads to widespread confusion between two separate and distinct but similarly sounding acronyms (EHS and EMS).

Since these two acronyms are used extensively throughout this report, it is important to clearly understand the meaning of each:

EHS -- Emergency Health Services encompasses all the health and medical related activities which would be required in very large scale national disasters and in a national crisis such as general war. The services would include:

- *Emergency medical care,*
- *Management and control of all health resources including personnel,*
- *Emergency transportation and communication,*
- *Maintenance of vital statistics,*
- *Sanitation,*
- *Nutrition,*
- *Epidemic surveillance and control,*
- *Rehabilitation services,*
- *Mental health,*
- *All other public health related services.*

EMS -- Emergency Medical Services encompass only those activities which have a direct bearing on the actual delivery of emergency medical care either in national crisis or in lesser emergency situations. These activities would essentially be limited to:

- *Emergency medical care,*
- *Emergency transportation and communication.*

Therefore, EMS as such should be thought of as being one operational component of an overall EHS organization. The fact that the United States Government is currently funding an EMS program whose primary mission is not national crisis or war related and whose entire orientation is immediate response has led to some widespread confusion on the part of Federal, state, and local health planners.

The existing EMS program, as intended by the Federal Government and in actual operational application across the country, is a system designed to coordinate and improve the every day emergency response of the medical resources in a specific area. This involves planning for and management of casualties resulting from airplane or train accidents down to an improved response to the single casualty situation. EMS is involved in the every day application of emergency medical care. It is concerned with the actual medical and surgical management of the individual casualty.

The above discussion of EHS/EMS is presented to clarify the existing operational distinction between the two and to insure that the reader is aware of these differences as the terms are applied throughout this report.

This report is divided into seven chapters and includes several appendices. To facilitate review, each of the chapters are briefly described below. Several appendices, as noted in the Table of Contents, are provided for more detailed references.

Chapter I -- *Introduction*

Chapter II -- *Public Health Service Mobilization Activities* -- This chapter presents a historical overview of the EHS activities sponsored by the Federal Government.

Chapter III -- *Non-HEW Health Related Emergency Planning and Operational Responsibilities* -- This chapter outlines the EHS related agreements between the Public Health Service and other agencies of government. It also presents a discussion of the EHS related role of the military and the organizational structure of the Federal Emergency Management Agency.

Chapter IV -- *Current Status of Emergency Health Services Planning* -- This chapter presents the investigators' interpretation of the current status of Emergency Health Service Planning. The findings are based on extensive discussions with central and regional Federal staff as well as health department personnel in Delaware, Pennsylvania, Maryland, Virginia and West Virginia.

Chapter V -- *Pertinent Legislation* -- This chapter contains a fairly detailed description of the legislative authority and the actual operational application of two laws which do not now, but could have a significant impact on future EHS planning activities.

- *Health Planning and Resources Development Act of 1974,*
- *The Emergency Medical Services Systems Act of 1973.*

Chapter VI -- *The Emergency Health Service Planning Process* -- This chapter includes a broad overview of EHS planning concepts, a discussion of the operational distinction between EHS and EMS and a series of suggested EHS operational responsibilities.

Chapter VII -- *Conclusions and Recommendations*

While reviewing this report, one should keep in mind that, aside from personal opinions regarding the operational feasibility of an EHS system, there would be a massive deployment of medical and health services in the event of general war. The common objective, therefore, should center on those pre-crisis planning activities which would maximize the efficient application of the surviving resources.

II. PUBLIC HEALTH SERVICE MOBILIZATION ACTIVITIES

A. ACTIVITIES PRIOR TO 1959

In the years following World War II, Federal authorities began to give serious thought to the need for an organization adequate to cope with national disaster situations. The primary basis for civil defense, since World War II, had been legislation enacted between 1947 and 1950, i.e., the National Security Act, the Defense Production Act, the Federal Civil Defense Act and minor modifications to this legislation in 1953.

Some consideration was given in the early 1950's to the establishment of a Federal department to be responsible for civil defense. However, a group of management consultants, hired to examine the problem, advised against such a proposal -- advocating instead, the incorporation of civil defense functions into the program of existing agencies.

The importance of health planning in civil defense was pointed up by the fact that the first delegation of responsibility under the Federal Civil Defense Act was made to the Department of Health, Education, and Welfare, and approved by the President in 1954. Shortly afterward, a modest program was formulated by the PHS to help meet the demand for emergency health services. The program was three-fold in nature:

- *Planning and program development,*
- *Recruitment and training, and*
- *Research and development.*

In 1955 the PHS provided indepth assistance to the Federal Civil Defense Administration in establishing the National Civil Defense Stockpile of Emergency Medical Supplies and Equipment, a nationwide network of health and medical resources which could be mobilized rapidly in the event of attack. In 1956 these programs were moderately expanded and accelerated in a cooperative effort between the Public Health Service and the Health Office of the Federal Civil Defense Administration.

Funds were cut back in fiscal year 1958 and numerous research and development activities, begun earlier by the Public Health Service, had to be curtailed. From July 1957 to May 1959, civil defense planning and health program development was limited. However, liaison with various agencies concerned with the health aspects of civil defense was maintained and whenever possible delegated responsibilities were built into normal Public Health Service activities.

On July 1, 1958, the Federal Civil Defense Administration and the Office of Defense Mobilization were combined into the Office of Civil and Defense Mobilization. At that time, consideration was given to the delegation of additional health responsibilities to the Department of Health, Education and Welfare to further utilize the capabilities of the Public Health Service and other departmental agencies having related health activities, i.e., Office of Vocational Rehabilitation and the Children's Bureau.

Delegated DHEW responsibilities were officially announced in the National Plan for Civil Defense and Defense Mobilization, published in October 1958. The health annex (Annex 18) to this plan outlined the following general areas of responsibility for the health agency:

- Develop civil defense health and civilian health mobilization plans and programs,
- Cooperate with professional health organizations and other governmental agencies in planning and administering nationwide programs for mobilization and effective utilization of health resources (manpower, material and facilities), and
- Develop joint plans for coordination of emergency health services programs of various Federal agencies (Veterans Administration, etc.).

All of the foregoing responsibilities were to be accomplished under the overall policy direction and in consonance with the programs of the Office of Civil and Defense Mobilization.

B. ESTABLISHMENT OF THE DIVISION OF HEALTH MOBILIZATION -- PUBLIC HEALTH SERVICE

The scope and nature of the delegated responsibilities of DHEW called for the establishment of an organizational unit to develop and implement health mobilization activities. Thus, in May 1959, the Division of Health Mobilization was established to carry out the emergency health responsibilities redelegated by the Secretary of DHEW to the Surgeon General, Public Health Service. These responsibilities were all affirmed by Executive Orders, one of which added management of the national civil defense stockpile of emergency medical supplies and equipment.

The overall emergency health preparedness goal established by the Public Health Service was to prepare and assist in the implementation of a program that would assure the availability of adequate health services for the civilian population in the event of a national emergency. Activities to achieve this goal were grouped into three major program areas.

- Preparation of the civilian to meet his own health needs when deprived of the services of a physician.
- Assistance to states and local communities to develop and implement effectively their emergency health plans.
- Development of a coordinated emergency program for Federal agencies having health related responsibilities.

In October 1968 the Division of Health Mobilization and the Emergency Health Services Branch, Division of Direct Health Services were merged to create the Division of Emergency Health Services. The responsibility for program planning for adequate medical care for day-to-day victims at the site of an emergency, during transportation to a hospital and in the hospital emergency department expanded the Division's functions to cover all elements of emergency medical care.

C. MEDICAL SELF-HELP PROGRAM

A program to prepare the general public to meet their own health needs when deprived of the services of a physician in a national emergency was introduced to health, civil defense and education leaders in late 1961. This program, known as "Medical Self-Help Training" was developed by the Division of Health Mobilization in cooperation with the Office of Civil Defense, Department of Defense and the American Medical Association. The program was inaugurated in 1961 through three national workshops held in different areas of the United States. Attendees included state leaders from the various health departments, civil defense and education offices, state medical societies and representatives of appropriate national medical, health and civil defense organizations. Program administration was accepted by the various states as a cooperative venture of the three state agencies (health, education and civil defense) and the medical societies. All program implementation was accomplished under state sponsorship with the Federal government providing the training materials.

In 1962, the program was launched with the objective of training at least one member of each family in the United States. By June 30, 1973, the Medical Self-Help Program was training more than 2 million persons per year and over 18 million persons had been trained when the PHS program was phased out.

D. ASSISTANCE TO STATE AND LOCAL COMMUNITIES

Public Health Service assistance to states and local communities in the area of emergency health preparedness had taken many forms over the past several years. During the peak program years, health mobilization program officers were placed in all DHEW Regional Offices, all State Health Departments and in eight of the nation's largest cities. These officials provided over-all policy interpretation and program direction in their geographic area of assignment. In addition, they encouraged state and community groups to develop and institute effective emergency health plans and training programs; provided technical advice in health resource evaluation and management and coordinated health mobilization activities inter-state and regionally. Specifically, those program officers assigned to state health departments provided staff services to communities in their efforts

to develop and implement emergency health preparedness measures that would make the most efficient use of scarce health resources. These assignees assisted in emergency health services program planning, in conducting local training activities, in determining health resources needs and in coordinating the emergency health program with other civil defense activities in the area. Reduction-in-force procedures, completed June 30, 1969, severely limited field assistance capabilities. Regional, state and metropolitan assignees were reduced from 77 to 44.

E. EMERGENCY HEALTH SERVICE TRAINING ACTIVITIES OF THE PUBLIC HEALTH SERVICE

Training held a high priority in the implementation of emergency health plans. Until 1969, the Public Health Service conducted a number of state and local training courses aimed at attaining a high level of community emergency health capability. A major focus of this training was toward developing a select corps of trainers who in turn would go out and train others.

During the period 1958-1972, the Public Health Service had evaluated and recommended training methodology, prepared and distributed training kits and developed informational and educational materials. Manuals and other training and guidance materials were prepared by the PHS for direct application to operation of the Packaged Disaster Hospital, establishing community health services organizations, preparing hospital disaster plans, management of health resources, providing medical care in shelters, and creating a medical self-help capability.

With the broad range of training materials and systems available to all medical and related disciplines, a means was furnished which could enhance the ability of all communities in their efforts to provide maximum effectiveness in emergency health care programming. EHS curriculum was developed at over 1,500 professional schools and colleges including medical, dental, veterinary medical, nursing, hospital administration and pharmacy.

F. THE NATIONAL EMERGENCY MEDICAL STOCKPILE

The emergency medical stockpile, management of which was delegated by Executive Order to the Public Health Service in 1959, reached a maximum dollar value of more than $200,000,000. In addition to bulk medical stocks which were stored in various national depots, the program in its peak years included more than 2,100 Packaged Disaster Hospitals (PDH) prepositioned in selected locations throughout the country and more than 1,300 Hospital Reserve Disaster Inventory (HRDI) units placed in selected community hospitals. All of the HRDI units and many of the PDH's were affiliated with hospitals under written agreements between the Federal government, the hospital and the custodial state. These agreements obligated the state to fulfill certain responsibilities of storage, inspection, care, maintenance and certification as to the condition of the unit on a continuing basis. The affiliated hospital was to attempt rotation of the short shelf-life items and otherwise maintain the supplies in a ready condition for use in emergencies. Parallel responsibilities were imposed on the Federal government and compliance activities were coordinated among all parties by health mobilization program advisors assigned to the states.

Budget cuts during fiscal years 1970 and 1971 reduced the emergency medical stockpile maintenance program to a holding operation. The reduction of funds and accompanying attrition of staff created major problems in the emergency medical stockpile program as follows:

- o No personnel were available to perform quality control functions, onsite inspection, inventory, servicing or rehabilitation of prepositioned PDH or HRDI units, and
- o No procurement funds were available to replace deteriorated stocks or procure new stocks to continue refurbishment of PDH's or assemble new HRDI units for prepositioning in communities.

Congressional action eliminated funds for emergency medical stockpile activities in the 1973 appropriation and PDH and HRDI prepositioning program actions ceased as of July 1, 1972.

G. THE FEDERAL EMERGENCY HEALTH SERVICES ORGANIZATION

Historically, DHEW policy has required that, upon proclamation of a national emergency, the Department should become the Emergency Health and Welfare Service (EHWS). By delegation the Secretary of DHEW assigned to the Surgeon General of the PHS the responsibility for developing the organization and operational capability of the Emergency Health Services (EHS) portion of the EHWS. The PHS has prepared plans for a standby organization which consolidates selected activities of the existing Federal health service agencies including the Veterans Administration and which becomes the Federal Emergency Health Service in a declared emergency.

The objectives of the Federal Emergency Health Service organization are to:

- Meet an unprecedented situation wherein all health agencies of government at all levels would be involved.
- Provide an organizational structure suitable for an immediate shift into Federal emergency command channels.
- Provide for health services under post-attack conditions.
- Provide maximum and effective utilization of Federal health employees.
- Provide a knowledgeable planning group to advise the chief, EHS, on emergency operations and plans for return to pre-emergency operations.
- Insure the mechanism for implementation of emergency services.

The Federal Emergency Health Service is described in detail in Chapter 4 of the PHS Emergency Manual, Appendix A.

H. PHASEOUT OF THE PHS EMERGENCY HEALTH SERVICES PROGRAM

Activities of the PHS emergency health program for fiscal year 1973 were restricted by the language of the appropriation act which scaled down community preparedness activities and discontinued the emergency medical stockpile program.

A 1973 letter from the Secretary, HEW to the Chairman, Subcommittee on Treasury, Postal Services and General Government, Committee on Appropriations, House of Representatives, contained the following statements:

"The 1974 Budget reflects the conclusion that the existing Department of Defense medical capability, particularly the Army Field Hospital system with its backup of medical supplies, should provide adequate protection for the civilian population as well as the military in the case of any major natural disasters. This same defense medical capability will also be the primary Federal contribution in the case of nuclear attack.

"With regard to community preparedness, the Department stands ready to provide technical assistance to communities through the regular staff in the Department's ten regional offices.

"Other activities of this program not related to the stockpile will be phased out as of June 30, 1973."

As a result, the Division of Emergency Health Services was directed to take those actions necessary to phase-out the total program.

The following is a brief summary of actions taken to accomplish the Division of Emergency Health Services phase-out.

- All of the PDH's were declared excess to department needs and were offered to other Federal agencies. A total of 124 PDH's were requested by other government agencies, including 114 by the Agency for International Development (AID). The remaining units were donated to state health departments and civil defense organizations under Federal surplus property programs. All units were donated on a "where is-as is" basis. Every effort was made to retain as many of these units as possible at their original locations.

- The HRDI units previously placed in community hospitals were offered for donation through surplus property channels. As with PDH's, recipients of these units were either the state health department or state civil defense organizations.

- Bulk medical stockpile items were disposed of by transfer to other government agencies, sale or destruction (in the case of unserviceable items).

- A special project office for emergency medical services was established and this activity was removed from the mission of the Division of Emergency Health Services prior to the June 30, 1973 phase-out deadline.

- Remaining Division stocks of training materials and other publications were transferred to state health departments, state civil defense offices and regional offices of the Defense Civil Preparedness Agency.

III. FEDERAL HEALTH RELATED EMERGENCY PLANNING AND OPERATIONAL RESPONSIBILITIES

A. INTRODUCTION

In the event of a national emergency the United States Public Health Service along with other major government agencies will have resource management duties and responsibilities. This chapter outlines those duties and describes the operational interrelationship between the various groups.

B. OFFICE OF DEFENSE RESOURCES

Effective utilization of resources in an emergency requires an organizational capability within the Federal Government to manage essential resources for maximum survival and recovery benefits. Under current policy the Office of Defense Resources (ODR) with the Federal Preparedness Agency (or its successor agency, i.e., the Federal Emergency Management Agency) as its nucleus will exercise this central directing and coordinating roles. The ODR is an organization which becomes operational only during emergency situations. It would be staffed by predesignated individuals from various existing government offices and its director would be named by the President. The ODR has presidential endorsement and approval. Plans for its implementation in an emergency are completed and the organization continues to be reviewed and evaluated during annual exercises.

Under the ODR concept there is a three-way functional break in the resources programming approach.

- *Claimant agencies -- the users of resources;*
- *Resource agencies -- the producers and managers of resources;*
- *The allocating and program policy agency (ODR).*

The role of each is described below.

1. Claimant agencies

Programs and claims on resources will be developed and presented to ODR -- the allocating and program policy agency -- by the claimant agencies responsible for:

- *the military program (DOD);*
- *the programs for the civilian population (HEW for civilian health needs -- for most other survival programs, claimant is DCPA); and*
- *the foreign aid programs (Department of State).*

The national resource programming operation is based on and directed toward meeting the survival needs of these major claimant agencies. These primary claimant agencies are charged with developing time-phased post-attack action plans and programs. The programs should be developed in a manner which permits a cost-benefit appraisal in terms of resources.

Once a determination is made by the ODR as to the apportionment of resources between major claimants, the amount so scheduled constitutes an allotment of resources which the claimant can rely on to carry out its mission. Thereafter, the claimant agency is completely responsible for the appropriate use of allotted resources as and when they are made available by the resource agencies.

2. Resource agencies

Resource (or logistical support) agencies are responsible for assessing the effects of attack on the remaining production or service potential in their area of concern. Resource agencies compile total claims received from claimants, verify their completeness and eliminate overlapping claims. These consolidated claims are then compared with the availability of the resource in the various projected periods and initial conclusions are drawn as to whether needs can be met or that there are areas of potential shortages. In the latter instance, the resource agency contacts appropriate claimants to ascertain whether the disparity can be settled by rescheduling or by adjusting requirements. The evaluation of remaining capacity to

produce goods and services should be reported to ODR in the same resource terms as claims are expressed.

When a decision is made by ODR as to the level of goods and services to be provided to meet total claimant needs, the responsible resource agency is directed to implement the program. The resource agency then assumes leadership in all steps needed to achieve the production goal. It is important for one resource agency to work closely with other resource agencies to obtain mutual logistical support in the determination of the goods and services (raw materials, labor, etc.) needed to meet particular production requirements. This secondary level of claimancy remains within the resource agency complex and is not under the purview of ODR.

3. ODR -- The centralized allocating and resource program policy agency

The ODR is responsible for the overall determination as to how remaining post-attack resources will be used. In order to accomplish this task, it must know what the effects of the attack or disaster are on the industrial complex and what the current and potential capacity is (provided by the Claimant Agencies). ODR must determine the proper balance among competing current demands, while at the same time it must make provision for future development of resource producing capabilities. ODR must deal with action programs and essential resource needs in broad terms. Decision by ODR will result in informing claimant agencies, again in very broad terms, as to what resources will be available to accomplish their mission. These decisions will also provide the resources agencies with their approved direction for production or service goals.

ODR will make resource policy determinations in broad terms such as program to provide survivor health care for civilian and military personnel; a fuel and energy program to meet both military and civil needs; a priority construction program for restoration of industrial capacity; etc. These determinations will be based on, and in support of, action programs of DCPA, DOD and other claimant agencies such as HEW. The allocation must be consistent with maximum capabilities for such support as reported by

the resource agency. It is important that a balance be maintained between demand and capacity to meet the demand.

The foregoing is a greatly simplified sketch of the ODR structure. However, it does serve to highlight an important centralized mechanism currently available in the Federal Government for making specific program decisions after consideration of alternative uses of the required resources. The objective of the ODR system is to coordinate, simplify and facilitate pre-attack planning and insure efficient post-attack operations in the resource management field.

Since the administrative structure of the government's emergency preparedness activities has changed substantially over the last several years, the following list of former and current specifications is included as a clarifying reference. Implementation of the new Federal Emergency Management Agency will necessitate further modifications.

Former Specifications	Current Specifications
Executive Orders 11000 and 11001	Executive Order 11490 (as amended by Executive Order 11921)
Defense Mobilization Order 8540.1	32A CFR, Chapter 1, Part 106, July 1, 1976
Office of Emergency Planning	Federal Preparedness Agency, General Services Administration
Division of Health Mobilization, PHS	Office of Administrative Management, PHS
DHEW Regional Health Director(s)	Regional Health Administrator(s)
Division of Emergency Health Services, Health Services and Mental Health Administration, PHS	Office of Administrative Management, PHS
Office of Emergency Preparedness or successor agency	Federal Preparedness Agency, General Services Administration
Executive Order 11490	Executive Order 11490 (as amended by Executive Order 11921)
Defense Mobilization Order 8500.1A	32A CFR, Chapter 1, Part 104, July 1, 1976
Assistant Secretary for Health and Scientific Affairs	Assistant Secretary for Health
Division of Emergency Health Services Regional Program Directors	PHS designated Associate Chiefs, Regional Emergency Health Service
Office of Civil Defense	Defense Civil Preparedness Agency

C. MILITARY SUPPORT OF CIVIL DEFENSE

The planning guidelines for military support of civil defense are presented in DOD directive 3025.10. The health and medical related guideline is extracted as follows.

> *"In the event of a National emergency involving a nuclear attack on the United States, the Joint Chiefs of Staff, and Military Services, and Defense Agencies will be prepared to employ available resources which are not engaged in essential combat support, or self-survival operations to assist civil authorities to restore order and civil control, return essential facilities to operation, prevent unnecessary loss of life, alleviate suffering, and take other actions as directed to insure national survival and a capability on the part of the nation to continue the conflict. In such employment established military organizational channels and pre-arranged plans will be followed when possible. A military commander, in making his resources available to civil authorities, is subject to no authority other than that of his superior in the military chain of command."*

The specific health related guidance provided in the DOD directive is listed below. As can be seen, items 4, 5 and 10 have health related implications. Since the other items are not health related they are titled only. It must be emphasized however that <u>military civil defense responsibilities are limited to supportive activities and then only after all military obligations have been met</u>.

> *"In the discharge of the mission, the Secretaries of the Military, the Joint Chiefs of Staff and the Directors of Defense Agencies, will take the necessary action to:*
>
> *'Develop and maintain plans and capabilities as necessary to assist civilian authorities in times of an emergency in restoring federal, state and local civil operations. Such interim emergency assistance will be in coordination with and supplementary to the capabilities of state and local governments and other non-military organizations and will be concerned with the following categories of assistance.*
>
> *'1. Restoration of facilities, etc.*
>
> *'2. Emergency clearance, etc.*
>
> *'3. Fire protection, etc.*

'4. Rescue, evacuation and emergency medical treatment or hospitalization of casualties, the recovery of critical medical supplies, and the safeguarding of public health. This may involve sorting and treating of casualties and preventive measures to control the incidence and spread of infectious disease

'5. Recovery, identification, registration and sanitary aspects of the disposal of the dead

'6. Radiation monitoring, etc.

'7. Movement control, etc.

'8. Maintenance of law and order, etc.

'9. Issue of food, essential supplies and material to include collection, safeguarding and issue of critical items in the post-attack phase

'10. Emergency provision of food and facilities of food preparation, should mass or community subsistence support be requested

'11. Damage assessment, etc.

'12. Provision of interim communication, etc.'"

The military role in support of Civil Defense is presented here in some detail specifically because there appears to be a serious misunderstanding in terms of health and medical support potentially available to the civilian sector.

While the DOD directive does require the military to "prepare and maintain plans, etc.," to support the civilian sector, it appears that this activity is not taking place in any meaningful way. Furthermore, as far as could be determined, planning activities regarding the management of military casualties are limited to the stateside management of military casualties generated in limited wars overseas.

An aspect of current planning which could have a substantive negative impact on the operational flexibility of civilian casualty management is that in the event of war overseas the military is planning on channeling a substantial portion of their casualty load into United States civilian hospitals. This would be accomplished through prearranged contracts to accept a given number of patients.

The numbers involved are thought to be from 15 to 20 percent of the hospital bed capacity.

Since limited wars overseas are possible precursors to nuclear attack upon the United States, this planning process should be closely coordinated with Federal, state and local civilian authorities who have civil defense related health and medical planning responsibilities.

The most serious misunderstanding regarding the role of the military stems from a statement of the Secretary DHEW* to the Joint Committee on Defense Production. In his summary of program activities for fiscal year 1973 the Secretary wrote:

> *"The 1974 Budget reflects the conclusion that the existing Department of Defense medical capability, particularly the Army Field Hospital System with its backup of medical supplies, should provide adequate protection for the civilian population as well as the military in the case of any major natural disasters. This same defense medical capability will also be the primary Federal contribution in the case of nuclear attack."*

This statement was a major justification for dismantling the PHS stockpile and other related activities. The last sentence implies that the U.S. military has sufficient defense medical capability to make a meaningful impact on a nuclear crisis situation. This is not true. The military does not have such resources, and has no intentions or plans to carry out such responsibilities.

D. COOPERATIVE AGREEMENTS

The several departments and/or agencies which have health related cooperative agreements with PHS are:

- *Department of Labor*
- *Department of Commerce*
- *Department of Justice*
- *Department of Agriculture*
- *Veterans Administration*

* Also quoted in Chapter II, page 13.

The following is a brief description of the responsibilities of each group. A more detailed description is provided in Appendix B. While the following are summaries of official interagency agreements, time, organizational changes and operational circumstances have changed considerably and in fact in many instances the agencies may not be performing the functions as stated.

1. PHS agreements with the Department of Labor

> *"PHS, by delegation from the Secretary of HEW, is responsible for preparing national plans and preparedness programs for the organization, training, and utilization of health manpower for civilian emergency health services. Such plans are to be coordinated with DOL for assistance in implementing the program and providing additionally required supporting manpower.*
>
> *"DOL is responsible for developing national emergency plans and preparedness programs, policies and procedures for the mobilization and management of civilian manpower (other than health manpower) and for coordinating PHS health manpower plans with the over-all manpower program.*
>
> *"DOL therefore develops plans and issues guidance to increase the readiness of State Employment Security offices to assist the emergency health organization."*

PHS therefore will:

- o Coordinate health manpower plans with DOL.
- o Maintain capability to identify critical health manpower categories.
- o Develop plans for post-attack utilization of health manpower.
- o Issue health manpower planning guidance to states.
- o Develop plans to staff Federal civilian emergency health organizations.
- o Develop plans to increase health manpower through training and education.
- o Designate priorities to guide DOL's allocation of supporting manpower.
- o Identify critical health skill occupations.
- o Advise DOL on health related salary and employment measures.
- o Advise DOL on claimancy for supporting manpower.

DOL therefore will:*

- o Plan to automate data to accelerate location of health manpower.
- o Facilitate the post-attack referral of health manpower upon the direction of PHS personnel.
- o Plan for the retention of supporting manpower at medical facilities in the event of attack.
- o Plan for additional supporting manpower for health services as required and as possible.
- o Plan for the organization of preassigned teams for emergency health services.

In addition, both PHS and DOL agree to exchange all pertinent manpower data, promote cooperative planning at state and local levels, and keep each other appraised of all pertinent emergency publications.

2. PHS agreements with the Bureau of Domestic Commerce (BDC), Department of Commerce

> *"The PHS is responsible for directing the domestic distribution of health end-items following an attack upon the United States in accordance with policy guidance provided by the Director of the Federal Preparedness Agency.*
>
> *"These agreements herein are limited to plans and procedures covering the distribution of primary inventories of health end-items in the survival period immediately following attack upon the United States. Subsequently the PHS will allocate such end-items made available by the Federal Preparedness Agency or successor agency to all assigned sectors of the domestic economy.*
>
> *"The Secretary of Commerce develops preparedness programs covering the production and distribution of all materials except those delegated to other Federal departments and agencies. The responsibility for maintaining such preparedness programs in the industrial production sector has been delegated to the Director, Bureau of Domestic Commerce (BDC)."*

---

* Currently much of this activity appears to be the responsibility of the Federal Preparedness Agency (FPA).

PHS therefore, will provide BDC with direction and/or information regarding:

- o Distribution of primary inventories of health end-items.
- o Estimates of continuing requirements for health end-items.
- o Estimates of health facility requirements for maintenance, repair and operating supplies produced under BDC jurisdiction.
- o Estimates of major repair and construction requirements for essential health facilities.

BDC therefore will:

- o Distribute primary inventories of health end-items in accordance with PHS plans.
- o Estimate availability of health end-items to essential health facilities.
- o Authorize essential health facilities to place orders upon their primary suppliers of health end-items, industrial products and capital equipment.
- o Direct new production of health end-items to meet continuing requirements of essential health facilities.

3. PHS agreements with the Bureau of Narcotics and Dangerous Drugs* of the Department of Justice

"The agreements are limited to plans and procedures covering the distribution of inventories of controlled substances in the survival period assuming an attack upon the United States. During the recovery period, the PHS will allocate such quantities of controlled substances as are made available by the Office of Defense Resources (ODR). The control procedures and distribution methods of the BNDD shall be utilized."

PHS agrees to provide BNDD direction and/or information regarding:

- o Adjustment of controlled drug distribution patterns to meet local shortages.

---

* Bureau of Narcotics and Dangerous Drugs of the Department of Justice is now known as Drug Enforcement Administration.

- o Estimates of continuing requirements for controlled substances.
- o Procedures to meet immediate post-attack controlled substance requirements.
- o Control procedures at the retail level during the crisis period.

BND, following attack on the United States, will:

- o Authorize distribution of primary inventory of controlled substances in accordance with distribution patterns developed by PHS.
- o Authorize designated Civil Defense Narcotic Procurement Officers* to place orders upon their normal primary suppliers of controlled substances.
- o Release raw materials for new production to meet the continuing end-item requirements for health care.

4. PHS agreements with the Department of Agriculture

The Food and Drug Administration (FDA) by delegation from the Secretary, DHEW, is responsible for preparedness programs pertaining to the purity and safety in the manufacture and distribution of foods, exclusive of meat, poultry and egg products inspection responsibilities assigned to the Consumer Marketing Service (C&MS), and animal health responsibilities of Agricultural Research Service (ARS) of USDA.

To facilitate the inspection of food for safety and purity in the post-attack period, the PHS/FDA authorizes the following:

- o USDA Food Inspectors and Food Graders or USDA designated Food Inspectors and Food Graders may approve for DHEW, fruits, vegetables, dairy products, meat and poultry, eggs and products thereof, and grain which they inspect in the immediate post-attack period, as meeting DHEW emergency standards for safety and purity.
- o To attain the optimum cooperative utilization of available USDA designated personnel with inspection capabilities for inspection of food in the initial post-attack situation, PHS/FDA will provide such personnel as designated by USDA with appropriate guidelines for assuring compliance with basic policies for food inspection in the emergency period.

* Individuals authorized by the government to procure and dispense narcotics during emergency situations.

- o **Interagency coordination.** Officials of USDA and PHS/FDA shall confer on matters of joint concern and furnish plans for the efficient utilization of inspection services for post-attack operation.

  This agreement assures that:

  - Bulk foods in damaged facilities or foods in packages which have been broken will be inspected for purity and safety before use, and the inspector shall determine the appropriate disposition.

  - Damaged food manufacturing establishments and storage and handling facilities may continue to operate following any needed decontamination and minimum essential repairs.

  - Resumption of manufacturing or processing operations is permitted as soon as equipment is determined safe for use.

- o The following shall be the general guidelines for determination of food purity and safety in an immediate post-attack period:

  - *Fallout*. In areas where a responsible authority (local civil defense organization or other recognized authority) determines that within 24 hours of a nuclear detonation the level of fallout radiation has not exceeded an observed peak dose rate of 5 R/hr, fallout shall not be considered a serious problem as relates to food contamination. In areas where fallout levels exceed an observed peak dose rate of 5 R/hr within 24 hours of a nuclear detonation and those areas receiving fallout from several nuclear detonations, food inspectors and graders will pass as fit for consumption non-perishable and semi-perishable foods such as canned or bagged products processed and packaged before the attack if the can or package is undamaged and if the foods are not of types likely to have spoiled due to lack of refrigeration, or from other causes. For other foods, such as fresh fruits and vegetables, the decision on passing food for immediate human consumption will be on the basis of supplemental guidance provided in the pre-attack period.

  - *Biological Warfare*. Emergency food inspectors shall keep aware of the local disease situation in the local populace for evidence of biological warfare as may be related to the food products. Unless diseases are observed or are reported to the inspector as known in his area, food shall not be withheld from use for fear of biological warfare contamination.

- *Chemical Warfare*. Possibility of contamination of food by chemical warfare agents shall not be a basis for condemnation of food or withholding of otherwise safe food, unless the Office of Civil Defense or other responsible agency reports that chemical warfare agents have been detected in the area.

5. PHS agreements with the Veterans Administration, Department of Medicine and Surgery

"The Administrator of Veterans Affairs shall develop policies, plans, and procedures for the performance of emergency functions with respect to the continuation or restoration of authorized programs of the Veterans Administration under all conditions of national emergency, including attack upon the United States. This includes the emergency conduct of inpatient and outpatient care and treatment in Veterans Administration medical facilities and participation with the Departments of Defense and Health, Education, and Welfare as provided for in interagency agreements."

Following an attack upon the United States, the VA will:

- o Maintain jurisdiction over its medical facilities.
- o VA station directors shall retain full control of their resources and personnel.
- o VA facilities shall participate fully to meet local emergency medical needs.
- o Conduct emergency operations in accordance with prearranged plans and agreements with civil defense, PHS personnel and local health authorities.
- o Return facilities to primary mission as directed by higher VA authority in consultation with state and local civil defense and emergency health authorities.

IV. STATUS OF EMERGENCY HEALTH SERVICES

A. INTRODUCTION

This discussion on the status of emergency health services includes:

- o A brief overview of the newly organized Federal Emergency Management Agency (FEMA).
- o Excerpts from Executive Order 11921 which relate to health emergency preparedness responsibilities.
- o Current minimal levels of emergency preparedness to be established and maintained by DHEW during normal readiness conditions.
- o Actual overall status of emergency health services activities.

B. FEDERAL EMERGENCY MANAGEMENT AGENCY (FEMA)

The president has proposed and the Congress has agreed to a comprehensive reorganization of the Federal Government's emergency preparedness and disaster response programs. The reorganization provides for the consolidation of five existing agencies and six additional disaster related responsibilities into a single structure.

A new agency to be called Federal Emergency Management Agency (FEMA) will incorporate the following existing agencies and functions.

- o The Defense Civil Preparedness Agency (Defense Department), which administers the national civil defense program and provides planning guidance and financial assistance to state and local governments for attack, and as a secondary mission, natural disaster preparedness;
- o The Federal Disaster Assistance Administration (Housing and Urban Development), which coordinates and funds Federal natural disaster relief operations;
- o The Federal Preparedness Agency (General Services Administration), which coordinates civil planning for national emergencies;

- The Federal Insurance Administration (Housing and Urban Development), which manages the flood insurance and hazard reduction programs;
- The National Fire Prevention and Control Administration (Commerce Department), which administers the Federal fire prevention program in coordination with state and local governments;
- The community preparedness programs for weather emergencies, administered by the National Weather Service (Commerce);
- The Earthquake Hazard Reduction Program, Office of Science and Technology (Executive Office of the President);
- The Dam Safety Coordination Program, Office of Science and Technology (EOP); and
- The Federal Emergency Broadcast System, Office of Science and Technology (EOP)

The consolidated agency, reporting directly to the President, will also have two emergency functions not now assigned to any specific federal agency:

- Coordination of emergency warning, and
- Federal response to consequences of terrorist incidents.

On the basis of the above administrative consolidation, it is not clear just what the Emergency Health Service responsibilities will be in the context of overall FEMA activities. Moreover, it is also not completely clear as to whether or not those planning and operational emergency health related activities will be carried out within the administrative structure of FEMA, or remain where they now rest under executive order in the PHS. It would be anticipated that the latter will be the case, with perhaps a significant health related coordinating staff within FEMA staff.

C. HEALTH RELATED EXCERPTS FROM EXECUTIVE ORDER 11921

It is recognized that the establishment of FEMA will require a new series of emergency preparedness related executive orders. The extent to which these will impact on DHEW responsibilities is likely to be small since the core of the health related emergency preparedness function is now and most likely will remain, under the new executive orders, the responsibility of the Public Health Service.

The following excerpts are taken from the executive order which has been effective, with minor modification, during the period between the phaseout of the Division of Emergency Health Services to the present.

Executive Order 11921 dated June 15, 1976 amends the emergency preparedness functions which the President has assigned to each department and agency of the United States Government. The responsibilities assigned to the Secretary of the Department of Health, Education, and Welfare as they relate to health are extracted as follows:

> *"The Secretary of Health, Education, and Welfare shall prepare national emergency plans and develop preparedness programs covering health services, civilian health manpower, health resources, welfare services, social security benefits, and educational programs as defined below.*
>
> *"A. 'Emergency health services' means medical and dental care for the civilian population in all of the specialities and adjunct therapeutic fields, and the planning, provision, and operation of first aid stations, hospitals, and clinics; preventive health services, including detection, identification, and control of communicable diseases, their vectors, and other public health hazards, inspection and control of purity and safety of food, drugs, and biologicals; vital statistics services rehabilitation and related services for disabled survivors; preventive and curative care related to human exposure to hazardous agents (nuclear, biological and chemical); sanitary aspects of disposal of the dead; and food and milk sanitation. It shall be understood that health services for the purposes of this order do not encompass the following areas for which the Department of Agriculture has responsibility: plant and animal diseases and pest prevention, control, and eradication; wholesomeness of meat and meat products, and poultry products, in establishments under continuous inspection service by the Department of Agriculture; veterinary biologicals agricultural commodities and products owned by the Commodity Credit Cooperation or the Department of Agriculture; livestock; agricultural commodities stored or harvestable on farms and ranches; agricultural lands and water.*
>
> *"B. 'Health manpower' means physicians (including osteopaths); dentists; sanitary engineers; registered professional nurses; and other occupations as may be included in the List of Health Manpower Occupations issued for the purposes of this part by the Director of the Federal Preparedness Agency (GSA) after agreement by the Secretary of Health, Education and Welfare.*

"C. 'Health resources' means manpower, material, and facilities required to prevent the impairment of, improve, and restore the physical and mental health conditions of the civilian population.

"Health functions. With respect to emergency health services, as defined above, and in consonance with national civil defense plans, programs, and operation of the Department of Defense under Executive Order No. 10952, the Secretary of Health, Education, and Welfare shall:

"(a) Professional training. Develop and direct a nationwide program to train health manpower both in professional and technical occupational content and in civil defense knowledge and skills. Develop and distribute health education material for inclusion in the curricula of schools, colleges, professional schools, government schools, and other educational facilities throughout the United States. Develop and distribute civil defense information relative to health services to states, voluntary agencies, and professional groups.

"(b) Biological and chemical warfare. Develop and coordinate programs for the prevention, detection, and identification of human exposure to chemical and biological warfare agents as may be necessary to carry out the responsibilities involved in the provision of emergency health services, including the provision of guidance and consultation of Federal, state, and local authorities on measures for minimizing the effects of biological or chemical warfare.

"(c) Food, drugs, and biologicals. Plan and direct national programs for the maintenance of purity and safety in the manufacture and distribution of food, drugs, and biologicals in an emergency.

"(d) Disabled survivors. Prepare national plans for emergency operations of vocational rehabilitation and related agencies, and for measures and resources necessary to rehabilitate and make available for employment those disabled persons among the surviving population."

The executive order required the Secretary of Health, Education, and Welfare to prepare national emergency plans and develop preparedness programs covering (among other things.)

- **Health services**
- **Health manpower**
- **Health resources**

It is this executive order which defines emergency health services and provides the administrative basis for identifying the essential components of an EHS system. Whenever the term EHS is used it should be understood to encompass all of the following components in an emergency mode of operation:

- o Medical care (including nuclear, biological and chemical)
- o Dental care
- o Preventive health services
- o Safety of food, drugs, biologicals
- o Rehabilitation of disabled survivors
- o Vital statistics services
- o Disposal of the dead (sanitary aspects).

D. BASIC REQUIREMENTS FOR EMERGENCY PREPAREDNESS AND ASSISTANCE ACTIVITIES -- PUBLIC HEALTH SERVICES

Emergency preparedness responsibilities placed on DHEW under E.O. 11921 have been further delineated and are incorporated into the current DHEW Emergency Manual. Chapter 2-00 of that document describes minimal levels of emergency preparedness activities to be established and maintained by the Department during normal readiness conditions. These requirements apply to all Department headquarters and regional offices, constituent operating agencies (including PHS) and predesignated field installations which have been assigned a Federal emergency mission during the post-attack period. Compliance with these requirements will help assure total DHEW capability to accomplish its assigned emergency mission. Broad national program guidance and Federal assistance functions assigned to DHEW are also outlined in various other chapters of the manual.

E. SUMMARY OF REQUIREMENTS CHAPTER

- o *Assignment of Staff Responsibility:* Designate an official as responsible for the accomplishment of assigned emergency preparedness functions and incorporate duties into official position description(s) and functional statements

- *Plans:* Prepare and maintain written plans for emergency operations

- *Emergency Action Documents:* Prepare and maintain standby operating procedures, orders, delegations, and other documentation necessary for the performance of emergency functions

- *Duty Assignments:* Identify essential emergency functions and staffing requirements, make emergency duty assignments, and maintain rosters

- *Leadership:* Establish and maintain succession orders to assure continuity of leadership and command responsibility during emergency

- *Security:* Maintain the security of classified defense information, documents, facilities, and personnel clearance

- *Identification:* Issue proper identification credentials to personnel having emergency relocation assignments or authority to enter classified facilities, and maintain the integrity of the identification system

- *Training:* Provide training and orientation to prepare emergency assignees to perform their duties

- *Employees:* Inform employees of their civil defense responsibilities.

- *Facilities:* Establish, protect, and maintain facilities required for emergency operations

- *Communications:* Establish and maintain telecommunications equipment and systems required for post-attack operations

- *Alerting:* Establish and maintain alerting lists and procedures to assure that designated relocatees and other key officials receive prompt notification of defense readiness and warning conditions

- *Records:* Select and preposition at emergency operating facilities those vital operating record and reference materials which will be required for post-attack operations

- *Resource Management:* Develop and promulgate plans, systems, guides, standards and procedures required for the post-attack protection and management of assigned resources and facilities

- *Resource Data:* Gather and maintain resources information required for evaluation of emergency requirements

- *Tests and Exercises:* Periodically test emergency plans, measures, facilities, and systems, and accomplish necessary improvements

- o *Status Reports:* Collect and maintain preparedness status information; make periodic reports of progress

F. PUBLIC HEALTH SERVICE EMERGENCY PREPAREDNESS ACTIVITIES 1973 TO PRESENT

In a 1973 letter (Exhibit IV-1) the Secretary reminded the PHS (and the heads of all HEW operating agencies and regional directors) of the continuing need to maintain these minimum requirements pertaining to readiness measures for emergency situations. The Secretary's letter also directed that:

> *"Subject to the limitations of . . . authorities and available resources, you should, if a request is made, provide to your counterpart state and local agencies the emergency preparedness and planning guidance and consultation required by E.O. 11490 and such direct assistance as is authorized by the Disaster Relief Act."*

In response to the Secretary's letter and following the phase-out of the Division of Emergency Health Services, a small emergency preparedness staff was assembled and organizationally placed in the Office of Administrative Management Office of Assistant Secretary for Health. The following Exhibit IV-2 is a summary of the responsibilities which were assigned to this staff. However, because of staff size, adequate time and attention has not been devoted to these activities, particularly in the area of providing guidance to the field.

G. ACTUAL STATUS OF EMERGENCY HEALTH SERVICE ACTIVITIES

A substantial portion of the effort under this contract was devoted to discussions with Federal, regional and state personnel who have active emergency health and medical related responsibilities.

Federal personnel included individuals from the:

- o Defense Civil Preparedness Agency
- o Department of Defense
- o Department of Commerce
- o Federal Preparedness Agency
- o Veterans Administration
- o United States Public Health Service.

EXHIBIT IV-1

ARANDUM

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE
OFFICE OF THE SECRETARY

: Heads of Operating Agencies
Regional Directors

DATE: APR 10 1973

FROM : The Secretary

SUBJECT: Emergency Preparedness and Assistance

This memorandum is a reminder of certain minimum requirements pertaining to readiness measures for emergency situations. As summarized in the attached DHEW Emergency Manual, Chapter 2-00, "Basic Requirements," these are routine functions which are to be incorporated among the many regular management activities performed by your office or agency. The manual chapter rests, in turn, upon the requirements and assignments to the Secretary contained in Executive Order 11490.

Readiness functions which must necessarily be accomplished centrally on a Department-wide basis will continue to be performed by the Defense Coordinator who is responsible to the Assistant Secretary for Administration and Management and to me for over-all coordination, direction, and monitoring, and for providing representation and liaison to other departments and agencies in matters related to emergency readiness.

Some current proposals, such as the President's Reorganization Plan No. 1, pertain to emergency preparedness and disaster assistance, and will undoubtedly have an impact upon this Department. None, however, would significantly alter your responsibility for performance of the functions described in the attachment.

Subject to the limitations of our authorities and available resources, you should, if a request is made, provide to your counterpart State and local agencies the emergency preparedness and planning guidance and consultation required by Executive Order 11490 and such direct assistance as is authorized by the Disaster Relief Act. Services or resources requested by other Federal departments and agencies may similarly be provided to the limit of our authorities and resources, but shall normally be handled on a reimbursable basis.

Attachment

EXHIBIT IV-2

ACTIVITIES OF THE EMERGENCY PREPAREDNESS STAFF

OFFICE OF ADMINISTRATIVE MANAGEMENT

- Develops emergency health and medical services preparedness programs management planning and evaluation activities.

- Develops disaster relief and assistance policies, plans, and procedures.

- Promotes incorporation of emergency planning and preparedness functions into governmental health agencies and facilities.

- Develops and maintains stand-by Federal Emergency Health Service organization, staffing, operating policies and procedures.

- Develops national emergency plans and preparedness programs covering all civilian health and medical services; the mobilization, utilization, and management of civilian health manpower; and the management, acquisition, mobilization, utilization, and distribution of health materials and facilities.

- Appraises EHS program status at all governmental levels; plans and conducts periodic readiness surveys, tests, and exercises; maintains continuous review of governmental emergency health service plans and preparedness status; conducts special studies.

- Coordinates intra- and interagency EHS Planning, Programming, and Budgeting System; collects and analyzes program input, activity, and output data; prepares program activity and progress reports.

- Develops/critiques legislative proposals; determines potential impact of proposed legislation; maintains information of pertinent legal authorities.

- Maintains central library of Federal, state, city, and hospital emergency health operations plans.

- Manages Federal EHS Vital Operating Records Program.

- Develops and issues EHS readiness standards and guidance materials.

- Monitors emergency-related and disaster-related issuances to assure conformance to Federal policy.

- Develops EHS planning and preparedness guides for regions, states, and communities and hospitals.

Regional personnel contacted were from HEW Region III headquartered in Philadelphia and the states visited were:

- o Delaware
- o Maryland
- o Pennsylvania
- o Virginia
- o West Virginia

The above contacts varied from all day discussions to fairly short interviews depending on the time available, interest expressed and the specific subjects discussed.

It should be noted that in all instances a distinction was made and maintained between emergency health services and emergency medical services. It was clear that a significant misunderstanding exists in many areas with the result being that the terms are used interchangeably and therefore inaccurately.

The Federal contacts within DCPA and FPA generally recognize the distinction between EHS and EMS and moreover they generally feel strongly that EHS activities have not been receiving adequate emphasis at Federal, regional and state levels of responsibility for quite some time. The basic reason for this lack of emphasis is of course the fact that the United States civil defense program has been receiving a corresponding lack of emphasis. With this low profile in terms of Federal commitment to civil defense in general it of course follows that civil defense related programs everywhere would be similarly de-emphasized. A curious observation is that even though some non-PHS personnel recognize this basic lack of commitment on the part of their own organizations they feel that somehow HEW ought to have a more positive attitude toward planning for the health related aspects of a nuclear crisis situation. A partial explanation for this attitude probably rests on the concept of delegate agency funding. In the past the civil defense group was in a position to pass funds through its own budget appropriation to support civil defense related activity in other agencies and departments of Government. The PHS, being one such delegate agency, participated actively. In some cases this funding arrangement might have resulted in an inflated impression of the delgate agencies' commitment to civil defense per se.

The thinking within the PHS is generally similar except that there is a greater tendency to assume that EHS planning activity is more active than it in fact is. There is of course a Federal level EHS plan which is structured essentially as it was prior to 1973 when the stockpile and other civil defense related PHS activities were cut back. Individuals still possess emergency relocation duty assignments and the PHS Emergency Health Service responsibilities assigned under executive order 11921 are still in effect. In practice however the EHS programs in terms of disaster exercises, the provision of guidance to regional and state offices and the maintenance of appropriate data files etc. does not exist.

PHS regional offices reflect about the same situation with EHS being essentially overshadowed by EMS. This observation obviously is not meant to be taken as a negative comment on HEW Region III activities. It merely reflects the Federal position and the current flow of funding. It is anticipated that the same situation exists in all other HEW regional headquarters.

The situation in the five states which were visited is slightly different. The basis of the difference rests on the fact that the states actually have operational health and medical responsibilities, beyond the scope of EMS, which cannot be ignored. With the exception of Maryland whose EMS organization is not administratively part of the State Health Department, the EMS Coordinator generally has responsibility for whatever EHS requirements may exist from time to time. For example, coordinating the health aspects of a statewide response to large scale flooding would involve the mobilization and the application of resources beyond the scope of EMS organizations. Since states do have this type of operational responsibility they tend to place higher relative emphasis on a more comprehensive health care response capability than either their Federal or regional counterparts. This is not meant to imply however that states are actively engaged in developing plans to cope with the health and medical aspects of a nuclear war situation. None of the states visited have been active in this area for several years but they all have varying degrees of natural disaster preparedness activity. Specific observations on Federal, regional, and state emergency preparedness are listed on Figure IV-3. The tabulation is followed by general observations on the status at the state level.

FEDERAL, REGIONAL, STATE EMERGENCY PREPAREDNESS STATUS*

	Federal Headquarters	Regional Headquarters	State # 1 Delaware	State # 2 Maryland	State # 3 Pennsylvania	State # 4 Virginia	State # 5 West Virginia
EHS Plans Kept Current	4	3	3	4	4	2	2
Duty Assignments Complete and Succession Orders Current	4	4	2	3	3	2	1
Emergency Plan Tested Periodically	4	3	2	4	4	2	1
Training Provided Periodically	2	2	1	4	3	2	1
Alerting Charts Kept Current	4	4	2	2	3	2	1
Vital Operating Records Prepositioned	3	2	1	2	3	2	1
Preparation of Guidance for Lower Levels of Control	2	1	1	2	3	2	1
Availability of Current Health Resources Data on							
Health Manpower	5	2	3	2	4	3	2
Health Facilities	5	3	3	2	4	3	2
Health Supplies	1	1	1	1	1	1	1

* Code -- 1 = Lowest, essentially no activity.
2
3
4
5 = Highest, essentially comparable to the 1973 activity.

NOTE: These ratings are in terms of the EHS organization in National Crisis Situations such as nuclear attack upon the Continental United States.

FIGURE IV-3

- o No state is uniformly well-prepared to provide all the various emergency health services which would be required in a large scale national disaster. This may be attributed to:

  - lack of funds
  - apathy
  - deficiencies in coordination
  - lack of central planning
  - lack of Federal and regional guidance.

- o Degrees of readiness vary considerably among the states, some of which have made only token provision for war related emergency health operations. This may be a result of prior overdependence on Federal funding and operational support.

- o While most states have official EHS plans and have made emergency assignments, the operations have not been rehearsed in any significant manner and the capabilities have not been adequately tested.

- o The EHS/EMS Disaster Services relationships in all cases were unclear.

- o None of the states had received EHS planning guidance from the regional or Federal level for a period of several years. Some of the personnel who were not involved in EHS prior to 1973 have never seen any Federal guidance on the subject.

- o The medical self-help training program has been discontinued in all states, but one, is currently operating a state funded program at about 25 percent of the effort under prior Federal support.

- o All states but one have disposed of or otherwise let their Packaged *Disaster Hospitals* deteriorate.

- o No state is continuing to fund a Hospital Reserve Disaster Inventory (HRDI) or its equivalent.

- o All states but one felt that the EHS planning process (if it exists at all) should be built into the everyday administrative structure of the state government as opposed to standing alone as a separate function.

- o No state has a central repository of data on the statewide availability of health manpower, facilities and supplies. They all however have access to manpower and facility data. None have data on the availability of health supplies and equipment.

V. PERTINENT LEGISLATION

A. INTRODUCTION

Civil Defense officials are currently investigating the feasibility of massive population relocation in the event of a serious threat of general war. The concept is referred to as Crisis Relocation Planning (CRP) and it essentially involves the pre-attack relocation of persons from high to lower risk areas. Part of the current research deals with addressing the health and medical care requirements of the relocated population. The two laws reviewed in this chapter are discussed in some detail since with slightly altered emphasis they both could have a substantial role in the health and medical aspects of Crisis Relocation Planning.

In 1973 and 1974, two major health planning and medical care delivery programs were enacted into law. This chapter presents an overview of each program since they both have a potential impact on the EHS planning process. The two laws in question are:

- The Health Planning and Resources Development Act of 1974 (included as Appendix C).
- The Emergency Medical Services Systems Act of 1973 (EMSS) (included as Appendix D).

The EMSS act essentially provides funding for local grantee groups to improve the efficiency and generally upgrade the quality of emergency medical care delivery.

The Health Planning and Resources Development Act provides funding to establish a network of Health Systems Agencies (HSA's) to coordinate health planning and development in terms of resource management, utilization patterns and facilities construction.

B. THE HEALTH PLANNING AND RESOURCES DEVELOPMENT ACT OF 1974

While there is no specific intention in this legislation to provide the planning basis for EHS related health care planning it could potentially be of related value in that the administrative structures established by this legislation could, over time, be adapted to include an EHS component.

The Act establishes the following:

- Requires HEW to issue guidelines on national health planning policy.
- Establishes National Council on Health Planning and Development.
- Specifies procedures for designating Health Service Areas.
- Creates network of Health Systems Agencies (HSA's) responsible for health planning and development.
- Authorizes planning grants for HSA's.
- Authorizes HEW to enter into agreements with State Health Planning and Development Agencies designated by the Governor of each state.
- Creates Statewide Health Coordinating Councils.
- Authorizes grants for state health planning and development.
- Authorizes grants to six states for demonstrating effectiveness of rate regulation.
- Provides technical assistance for HSA's and state agencies.
- Establishes National Health Planning Information Center.
- Authorizes at least five centers for study and development of health planning.
- Revises existing Medical Facilities Construction Program.
- Provides assistance through grants, loans and loan guarantees for projects for:
  - modernizing medical facilities
  - building new outpatient medical facilities
  - building new inpatient medical facilities in areas which have experienced recent rapid population growth
  - converting existing medical facilities for providing new health services.

- Includes grant assistance to publicly owned health facilities for construction and modernization projects for eliminating or preventing safety hazards and complying with licensure or accreditation standards.

- Authorizes grants to designated HSA's to create Area Health Services Development Funds.

- Authorizes appropriations for transition of existing planning and related programs to the new Health System Agencies established under the Act.

The core of this program is the establishment of a network of Health Systems Agencies (HSA's). The civil defense related aspects of these HSA's in the context of current crisis relocation planning is that their geographic boundaries are generally governed by the availability of resources. Specifically the law provides that:

> *"HSA areas must be a geographic region appropriate for the effective planning and development of health services, determined on the basis of factors including population and the availability of resources to provide all necessary health services for residents of the area."*

- Each standard metropolitan statistical area must be entirely within the boundaries of a single health service area unless each Governor involved determines (and the Secretary approves) that in order to meet other requirements the area should include only part of the SMSA.

- Area boundaries, to the maximum extent feasible, must be appropriately coordinated with those of Professional Standards Review Organizations (PSRO's), existing regional planning areas, and state planning and administrative areas.

The HSA's themselves are required to:

- Gather and analyze data;

- Establish health systems plans (HSP's) -- plans and statements of goals and long-term objectives -- and annual implementation plans (AIP's);

- Provide technical and/or limited financial assistance to organizations seeking to implement the plans;

- Coordinate activities with PSRO's and appropriate planning and regulatory entities;

- o Review and approve or disapprove applications for Federal funds for health care facilities within their health service area;
- o Assist states in the review of capital expenditures proposed by health care facilities within their health service area;
- o Assist states in making findings on the need for new institutional health services proposed for the area;
- o Assist states in reviewing the appropriateness of existing institutional health services offered in the health service areas; and
- o Annually recommend to states, projects for modernizing, constructing and converting health facilities in the area.

While none of the above are specifically oriented to EHS considerations, it is obvious that the health related CRP planning process could benefit greatly through close liaison with the various HSA groups.

C. THE EMERGENCY MEDICAL SERVICES SYSTEMS ACT OF 1973 (EMSS)

Recognizing that most communities in the country were seriously deficient in capability to cope with accidents and other medical emergencies the Congress passed the EMSS Act of 1973. This act essentially provides support for the development of regional systems of emergency medical care. An emergency medical services system is defined in the law as one

> *". . . which provides for the arrangement of personnel, facilities, and equipment for the effective and coordinated delivery, in an appropriate geographic area, of health care services under emergency conditions (occurring either as a result of the patient's condition or of natural disasters or similar conditions), and which is administered by a public or non-profit private entity which has the authority and the resources to provide effective administration of the system."*

To conserve resources and improve the available services the EMS system is tailored to fit the requirements of a region rather than those of a specific town or even county. The entire country is divided into approximately 300 such regions. The law specifically requires that in order to establish an EMS system, fifteen components must be in place and working cooperatively, as follows

- o Provision of Manpower
- o Training of Personnel
- o Communications
- o Transportation
- o Facilities
- o Critical Care Units
- o Use of Public Safety Agencies
- o Consumer Participation
- o Accessibility to Care
- o Transfer of Patients
- o Coordinated Medical Record-Keeping
- o Consumer Information and Education
- o Review and Evaluation
- o Disaster Linkage
- o Mutual Aid Agreements

The EMS law includes an interpretative explanation of what specific activities are required under each of the fifteen components. The next to last, Disaster Linkage, is directly related to the "Civil Defense" responsibilities of the system. To be specific the law states that each EMS shall have a plan to assure that it will be capable of providing emergency medical services in the system's service area during mass casualties, natural disasters or national emergencies.

Support for the EMS system is provided by three units of the Public Health Service:

- o The Health Service Administration through its Division of Emergency Medical Service funds.
  - Feasibility studies and planning grants to determine the possibility of, and to plan for, the establishment and/or the expansion of an EMS system
  - Establishment and initial operation grants
  - Expansion and improvement grants
- o The Health Resources Administration through its Bureau of Health Manpower funds.
  - The EMS training program

- o The National Center for Health Services Research, Office of the Assistant Secretary of Health funds.
  - The EMS research program

The Federal support to EMS systems operates with specific time constraints.

- o Feasibility studies and planning grants are limited to one year of support. This is authorized under Section 1202(1).
- o Initial operation grants are limited to two years support with the first under Section 1203(1) and the second authorized in Section 1203(2).
- o Expansion and improvement grants are also limited to a two-year period under Sections 1204(1) and 1204(2) respectively.

The total support possible therefore for any given EMS is five years. Of the 304 existing EMS areas across the country the number in each of the funding phases, including those where funding has not yet been approved, is approximately as follows (data as of July 1978). The phases are keyed to the above mentioned sections of the act.

None	- 22	*No EMS funding as yet*
1202(1)	- 96	EMS Planning Grants
1203(1)	- 50	EMS Initial Operation Grants
1203(2)	- 68	EMS Initial Operation Grants
1204(1)	- 39	EMS Expansion Grants
1204(2)	- 29	EMS Expansion Grants
	304	

It is recognized that the primary objective of the entire EMS system is to provide better emergency medical care on a day-to-day basis and to improve the areas' capability to cope with large accident situations (i.e., plane crashes) or significant natural disasters such as floods, tornadoes, etc. The EMS system nationwide has already come a long way to meet this major objective.

The major EMS related issue, in terms of this report, is whether or not the objective "disaster linkage" as stated earlier should be interpreted as the assignment of planning and/or operational EMS responsibilities specifically related to the management of a nuclear war crisis situation. At this point it

must be emphasized that the EMS structure as it exists is primarily a funding conduit at Federal and regional levels and a coordination unit at the local level. At no point in the structure does the EMS organization per se exercise command and control authority. Each HEW region has a designated EMS Coordinator who provides technical assistance and planning guidance throughout the region.

Since the EMS structure does exist it would seem reasonable for HEW to focus in on it as the core organization in terms of implementing DHEW's war related executive order responsibilities. While EMS as such could serve as the EHS (medical operational organization) it should be noted that this is only part of the complete EHS package which in total would include the following components:

- o Planning
- o Health Manpower
- o Health Material
- o Health Operations

The administrative relationship between these components in the current planning for Federal Emergency Health Services is shown in Figure V-1.

The planning component coordinates activities and assures conformance with DHEW and national policy, recommends program adjustments, suggests legislation, advises on emergency programs, prepares overall program guidance.

The health manpower component determines availability and requirements for health manpower; establishes procedures to implement executive decisions to recruit, transfer and otherwise control health manpower; directs the interregional distribution and utilization of manpower for national survival and recovery; oversees pertinent national training programs.

The health material component essentially mirrors the manpower component with supplies and facilities rather than people.

The health operations component can be thought of as being responsible for the following service areas:

FEDERAL EMERGENCY HEALTH SERVICE ORGANIZATION

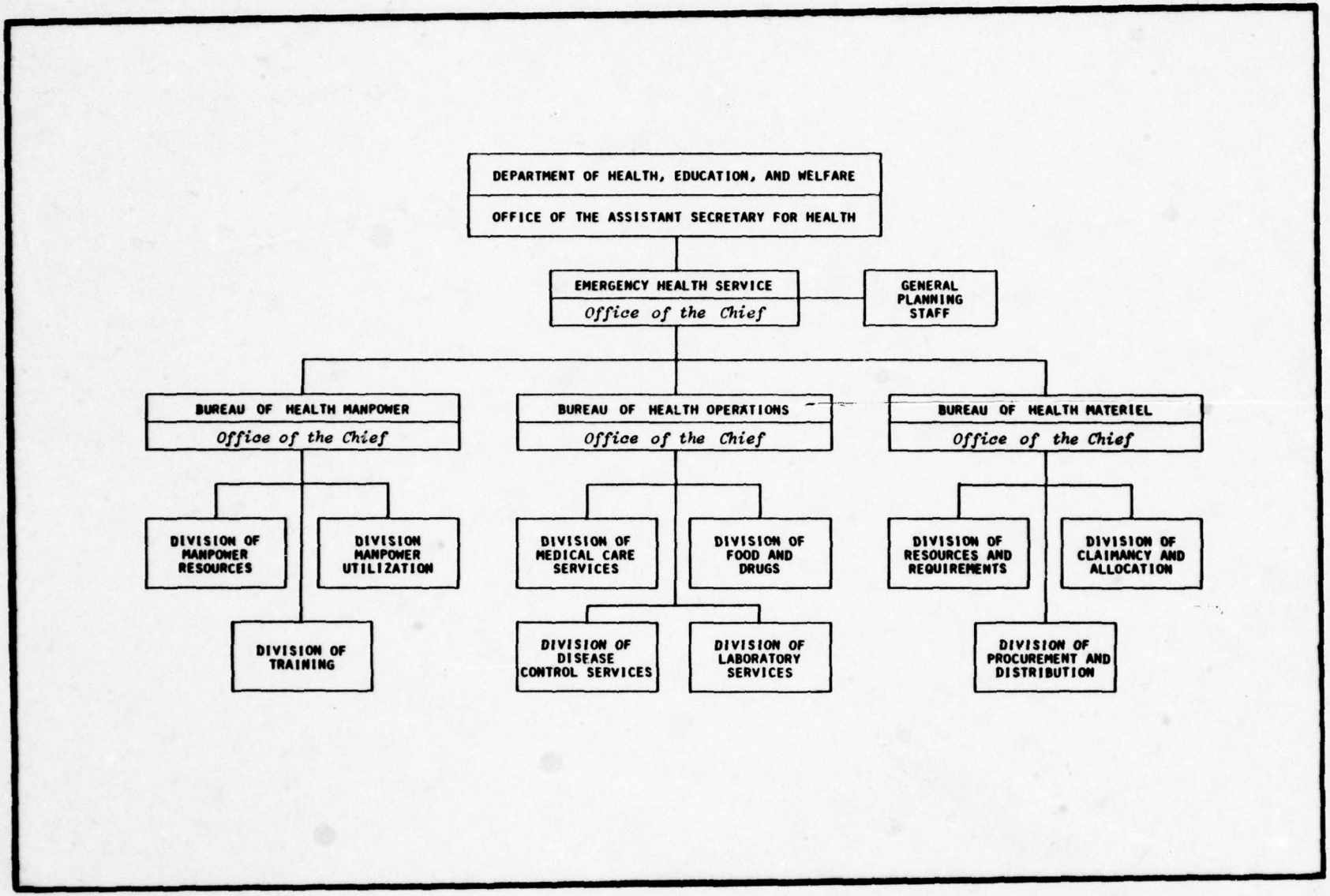


FIGURE V-1

- o Casualty care
- o Disease control
- o Community health
- o Physical and mental rehabilitation
- o Laboratory services
- o Safety and potency of drugs and biologicals
- o Safety of food supplies.

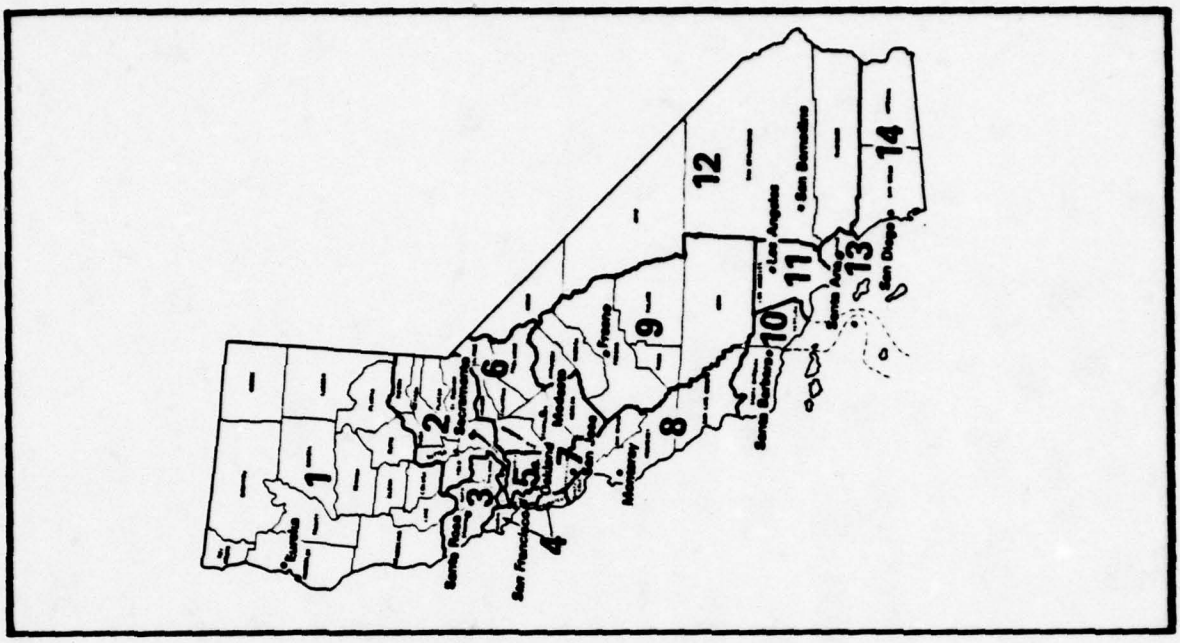
The EMS system as it now functions is essentially involved with just the casualty care aspects of health operations. This is not to imply however that its role should not be expanded. The principal problem associated with expanded function however would be the difficulty of inter-county coordination on such traditionally county based services as disease control and community health.

D. EMS HSA MAPS

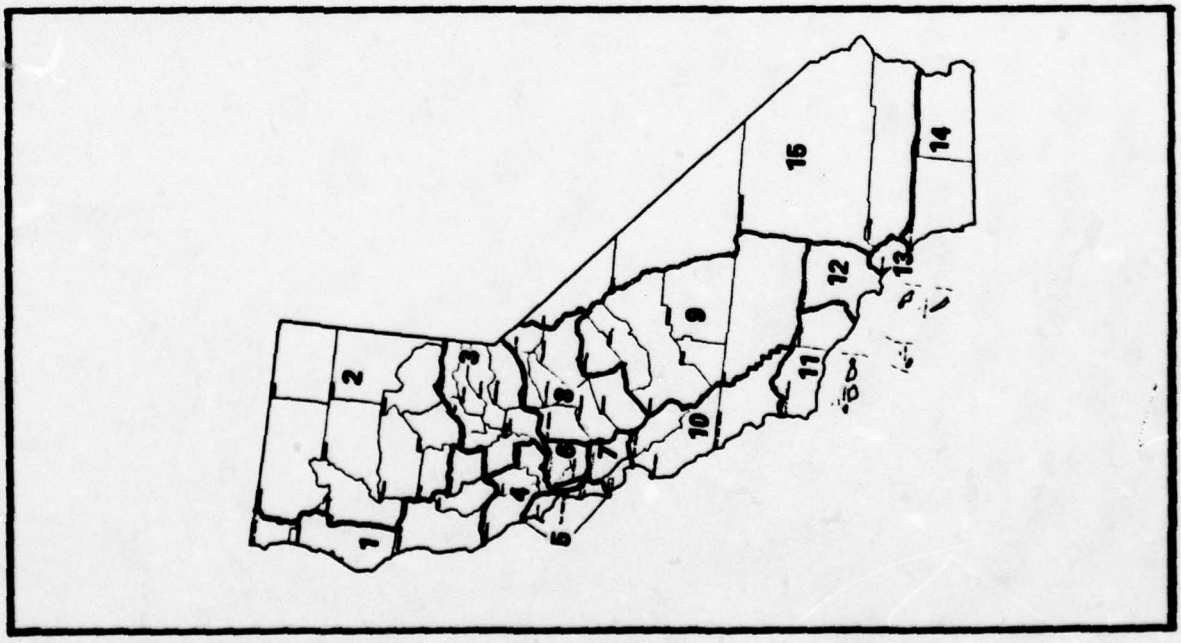
Figures V-2 to V-8 have been included to give some perspective as to the comparative sizes of Emergency Medical Services Regions and Health Service Areas. It should be noted that even though there are Federally established guidelines, the areas have been designated by the states themselves, therefore there is no nationwide uniformity in terms of population or area served by any given EMS or HSA system. Wyoming for instance has opted for a single statewide EMS, whereas other states such as Nevada with less than twice the population has opted for four EMS areas.

In most instances the HSA and EMS regions are very close if not identical. This is the general rule across the country with one HSA sometimes including several EMS regions but never the reverse.

CALIFORNIA



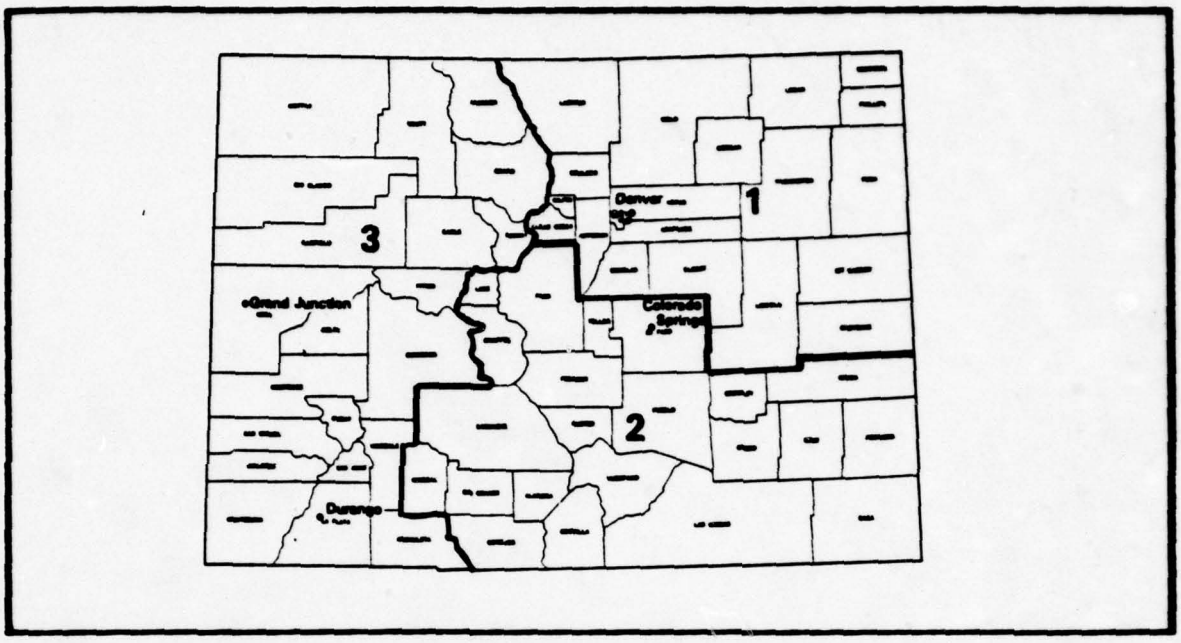
FOURTEEN HEALTH SERVICE AREAS



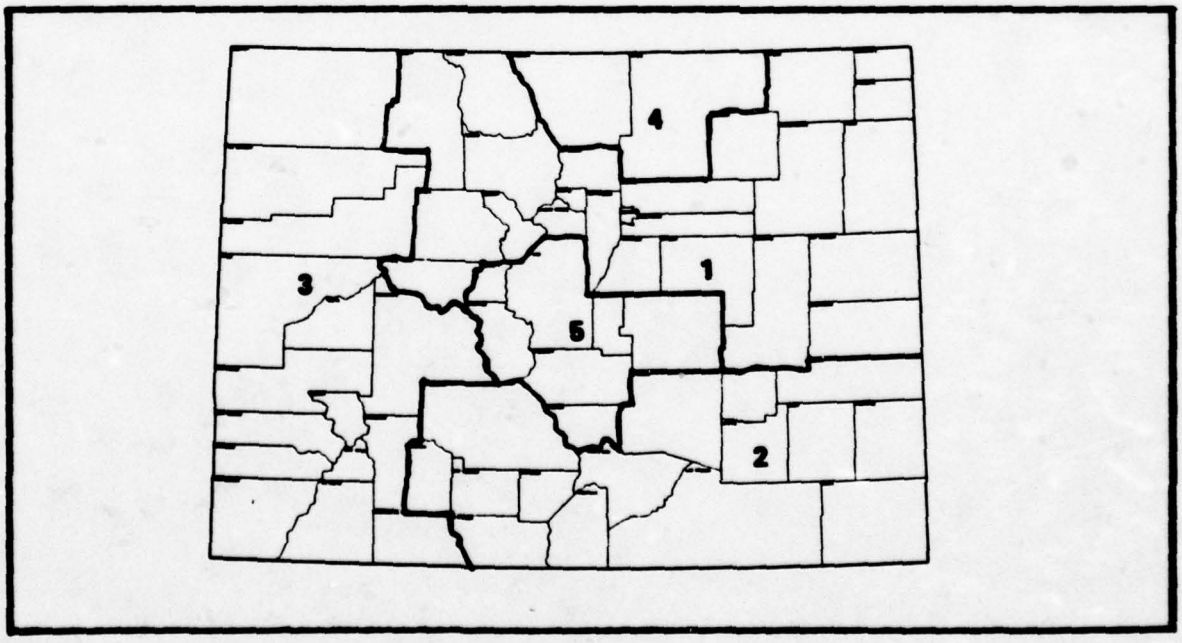
FIFTEEN EMERGENCY MEDICAL SERVICES REGIONS

FIGURE V-2

COLORADO



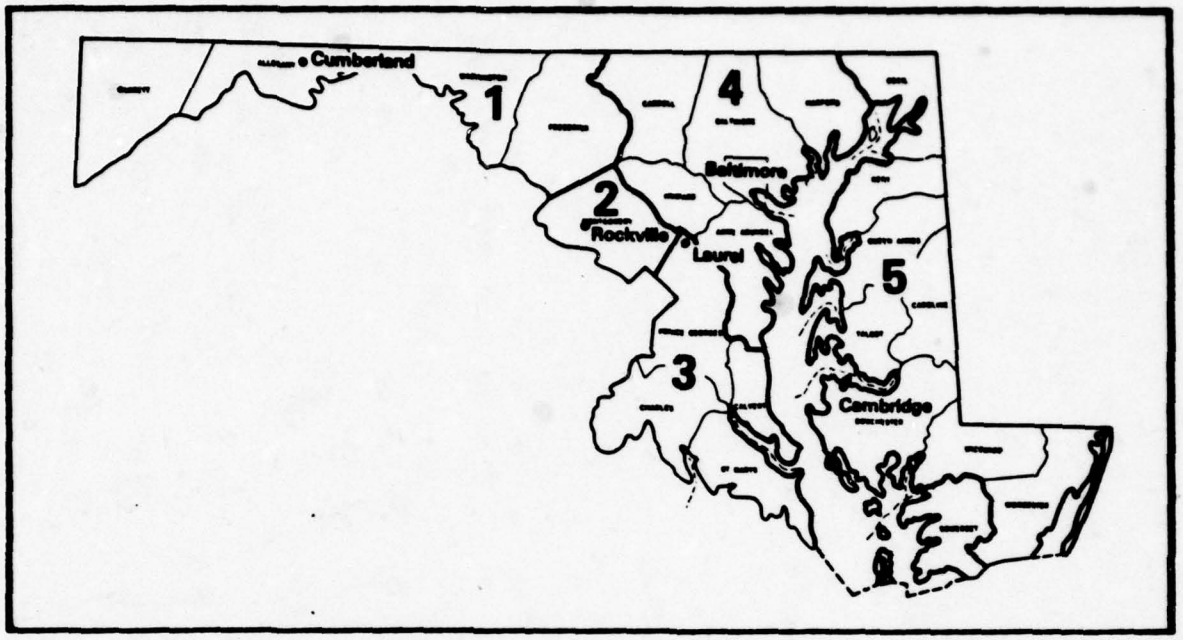
THREE HEALTH SERVICE AREAS



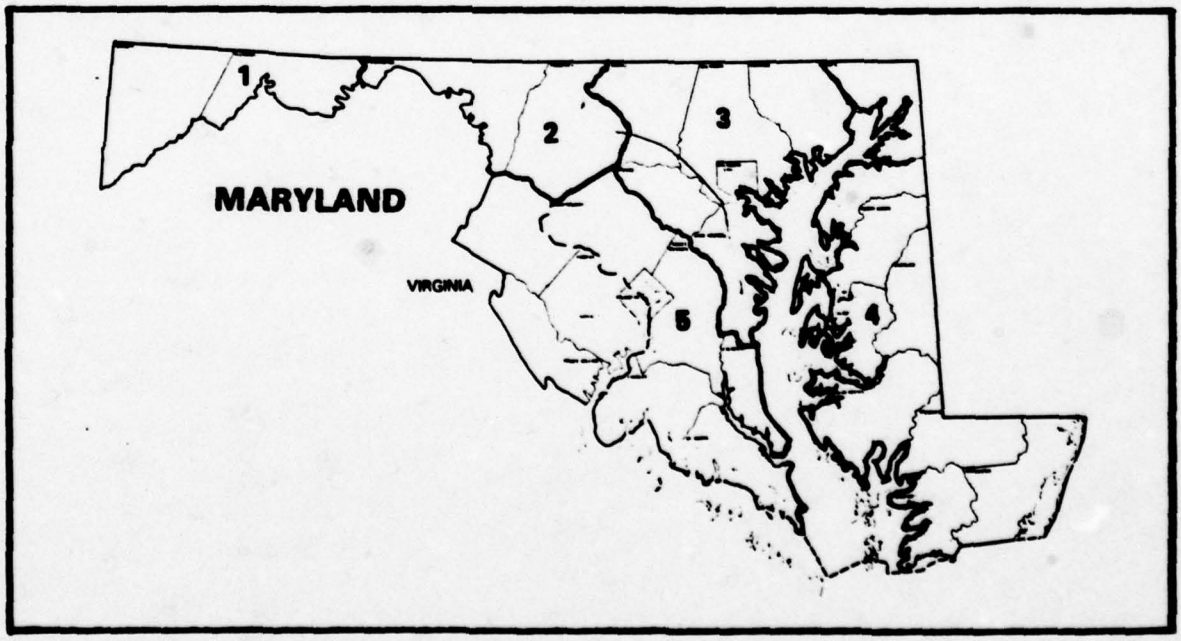
FIVE EMERGENCY MEDICAL SERVICES REGIONS

FIGURE V-3

MARYLAND



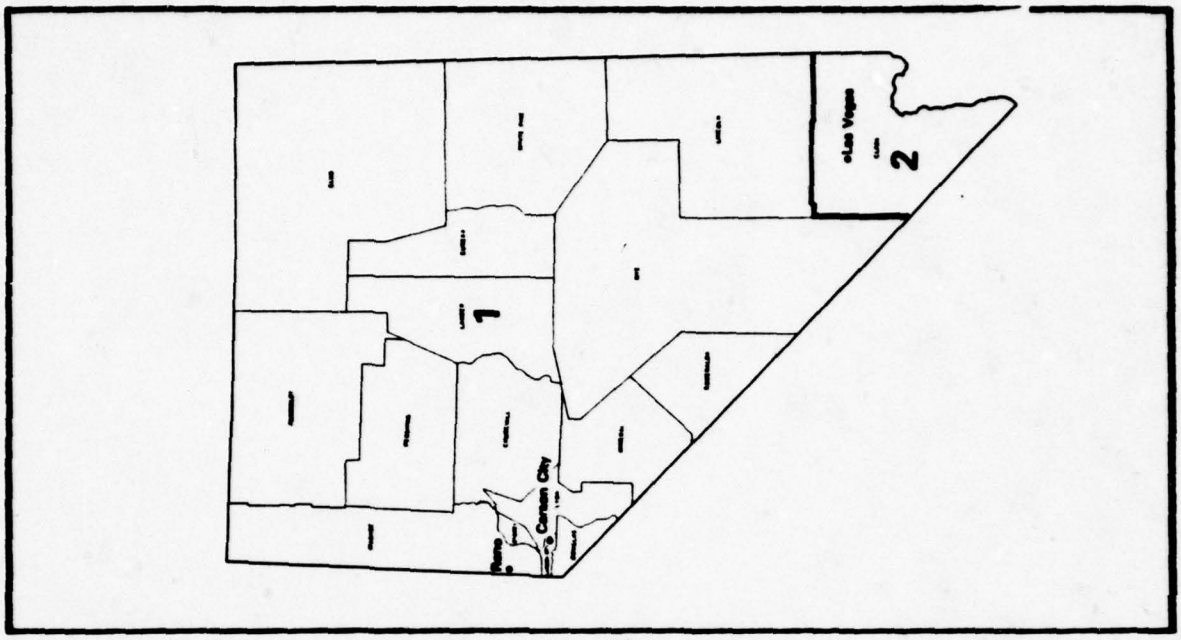
FIVE HEALTH SERVICE AREAS



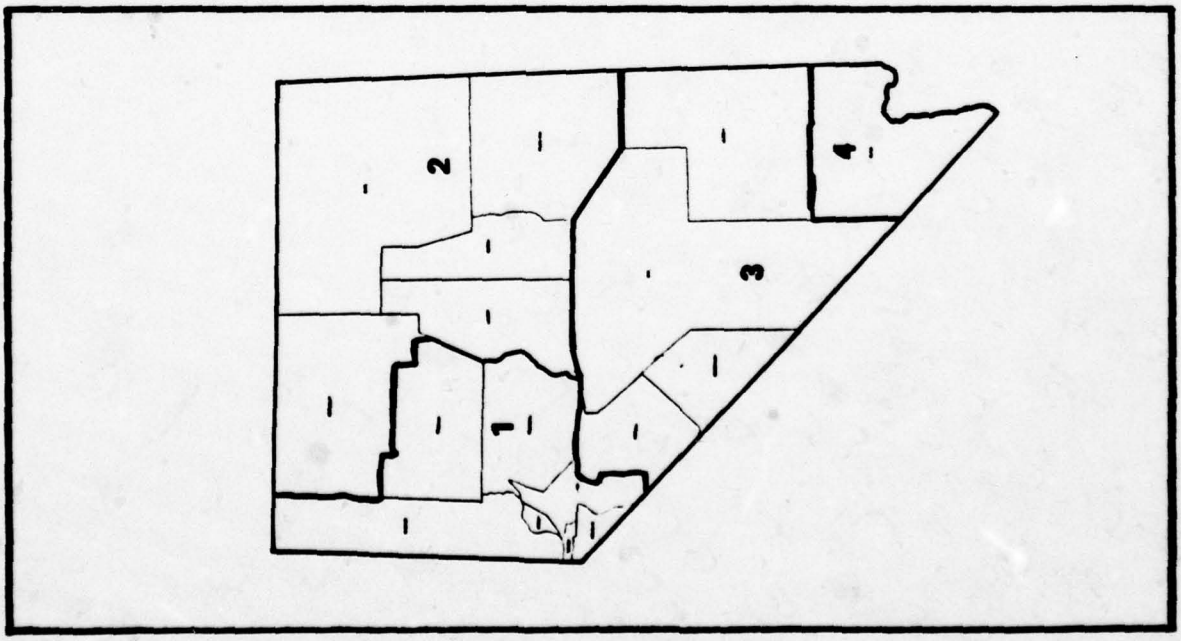
FIVE EMERGENCY MEDICAL SERVICES REGIONS

FIGURE V-4

NEVADA



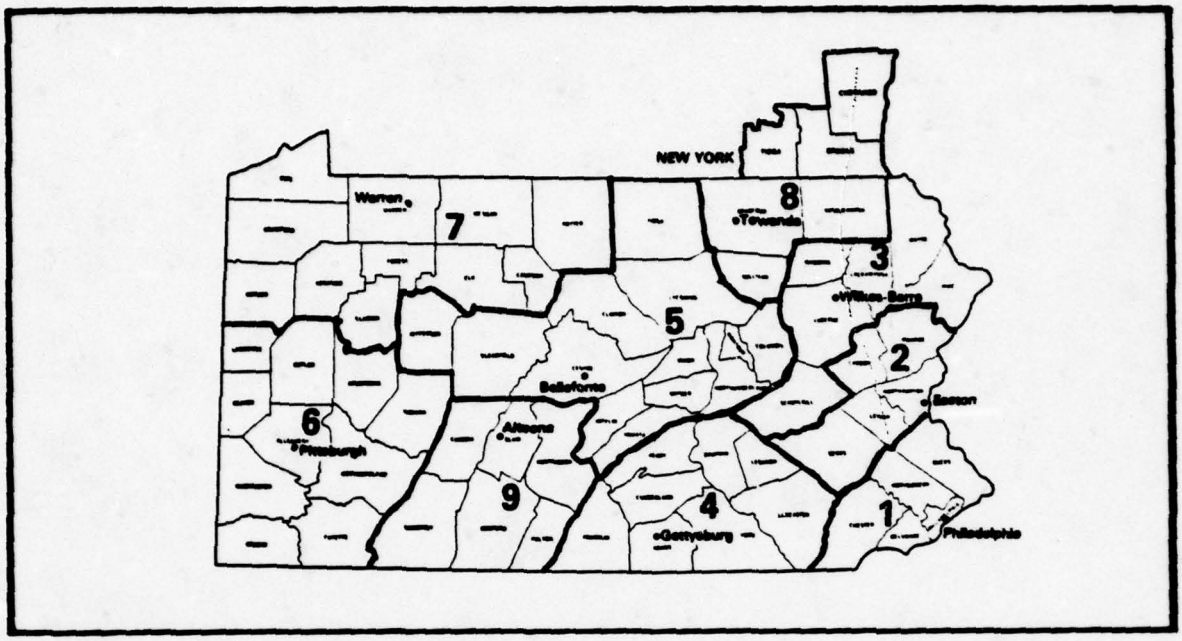
TWO HEALTH SERVICE AREAS



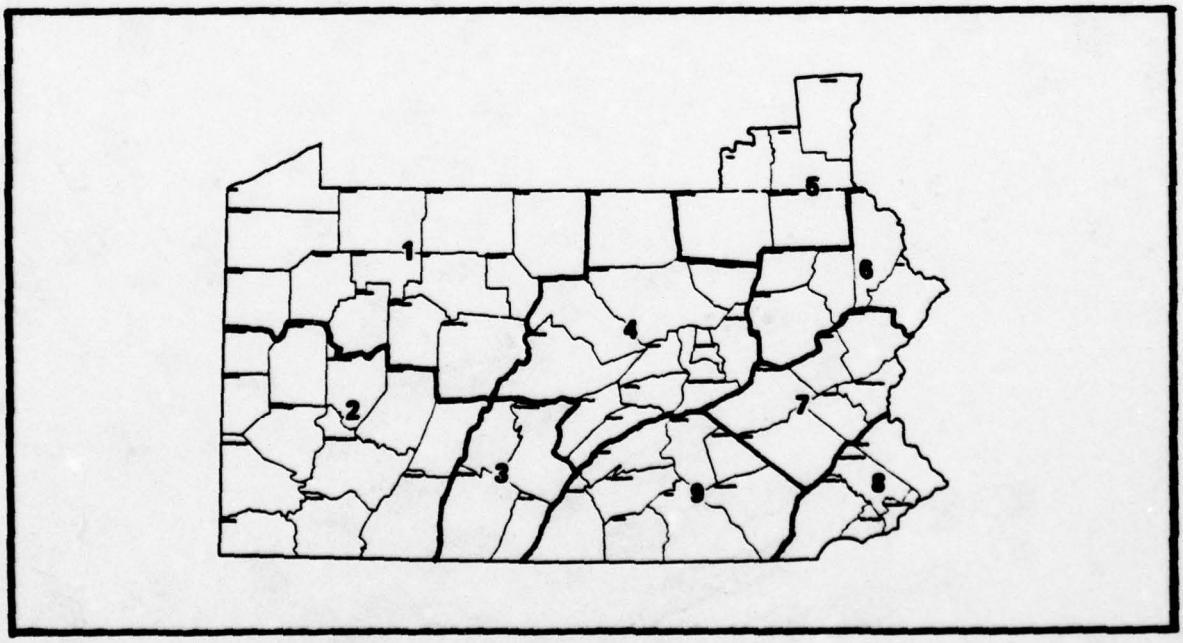
FOUR EMERGENCY MEDICAL SERVICES REGIONS

FIGURE V-5

PENNSYLVANIA



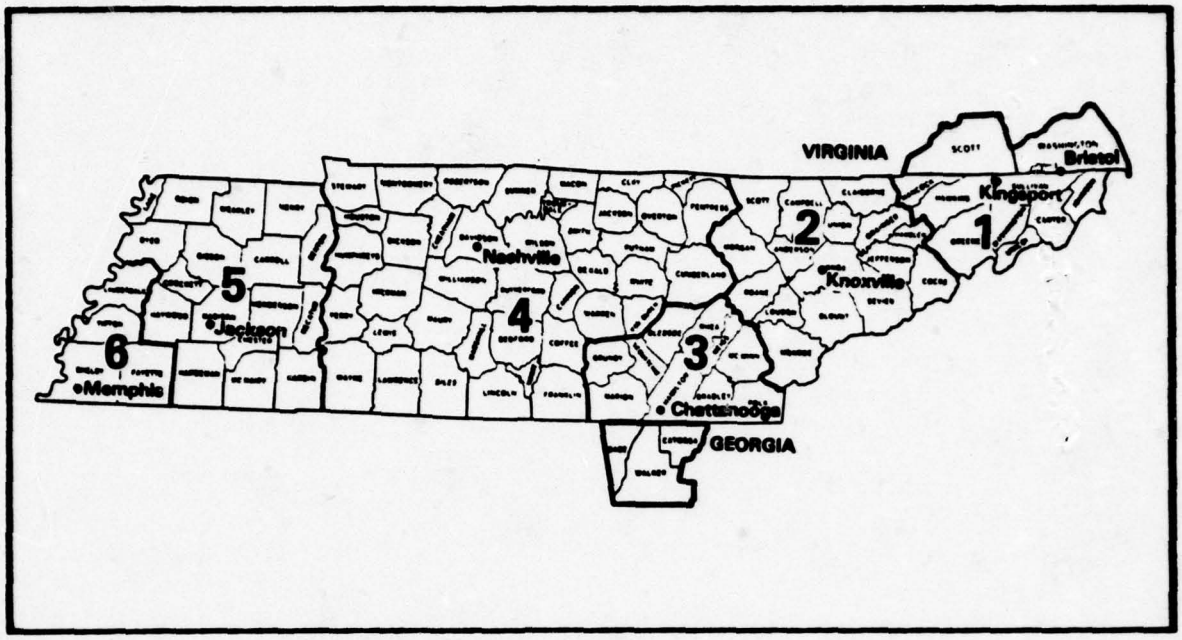
EIGHT HEALTH SERVICE AREAS



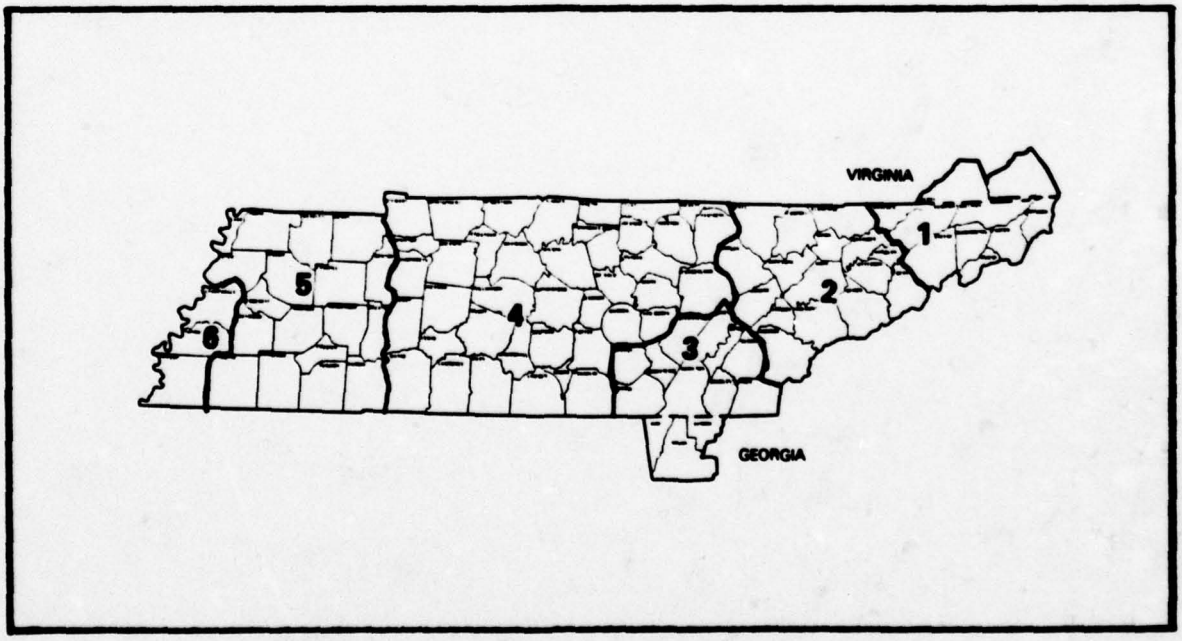
NINE EMERGENCY MEDICAL SERVICES REGIONS

FIGURE V-6

TENNESSEE



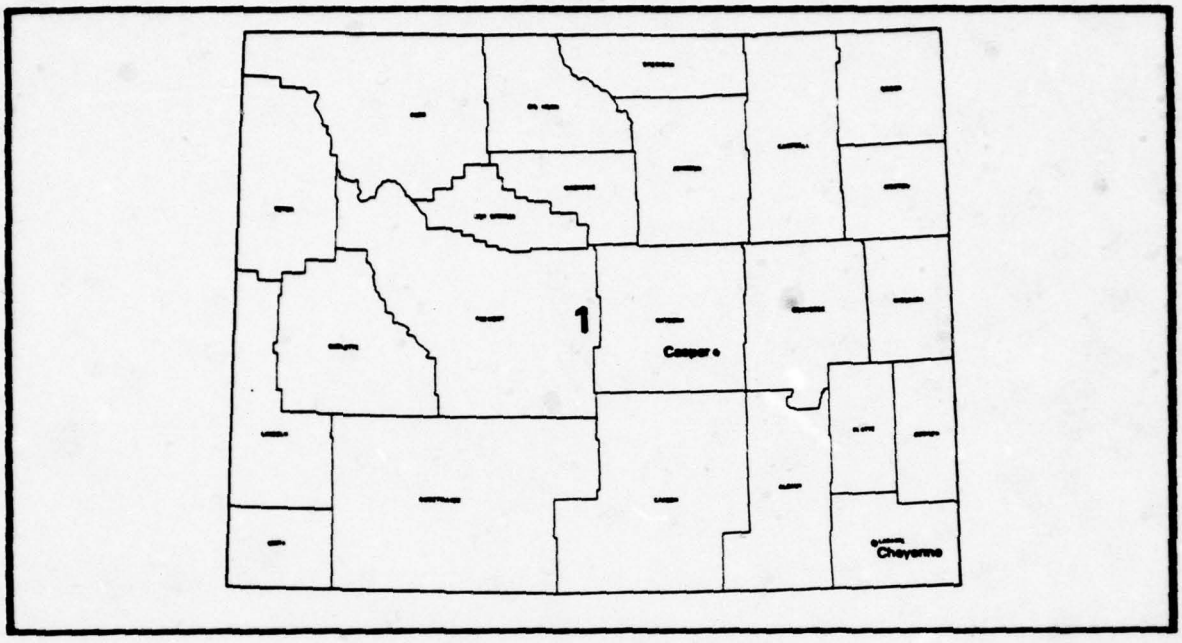
SIX HEALTH SERVICE AREAS



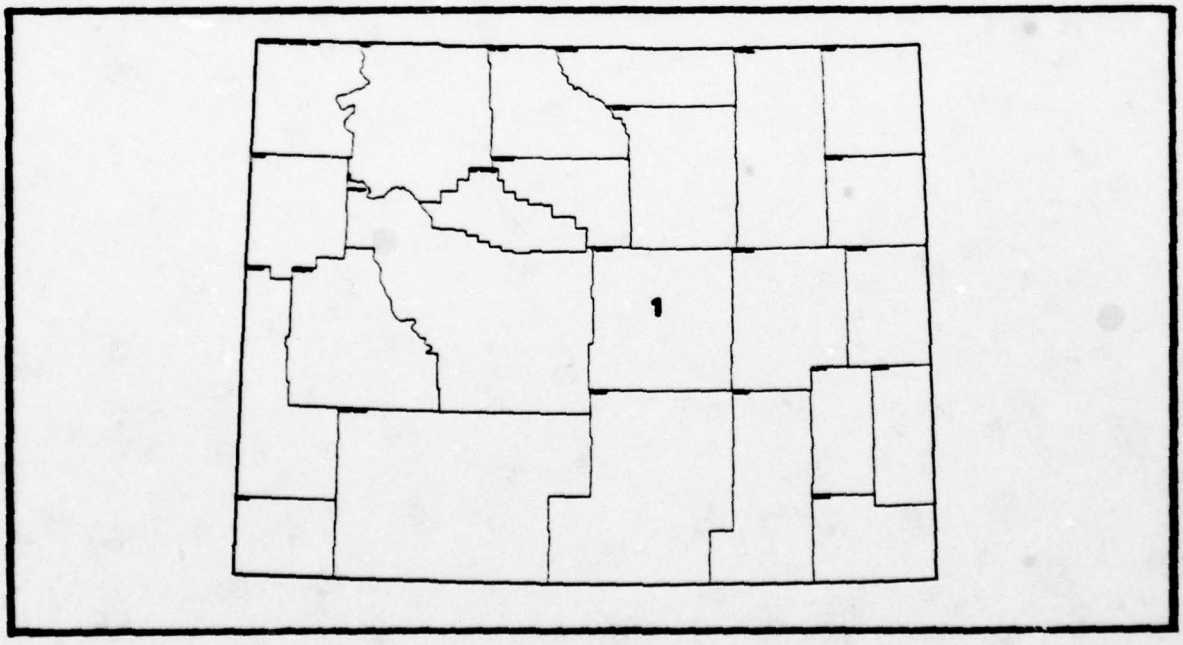
SIX EMERGENCY MEDICAL SERVICES REGIONS

FIGURE V-7

WYOMING



ONE HEALTH SERVICE AREA



ONE EMERGENCY MEDICAL SERVICES REGION

FIGURE V-8

VI. THE EMERGENCY HEALTH SERVICE PLANNING PROCESS

A. INTRODUCTION

In reference to the concept of Crisis Relocation Planning, the Washington Post lead editorial of December 15, 1978 began with

> *"They have been thinking the unthinkable again in certain quarters of government, and the question now is whether they are also going to try the non-doable."*

The editorial then goes on to make the case that any substantial civil defense program would be wasteful, dangerous and inherently ineffective. The final comment summarizes the newspaper's position.

> *"Embarking on a civil defense program in a nuclear-missile age is one of the worst ideas ever tossed into public discussion. The president should toll it out."*

While the Post's comments were directed toward an overall civil defense program involving population relocation on a massive scale, the general impression created was that no type of program makes any sense as a defense or as a countermeasure to nuclear attack. In terms of the emergency health service aspects of a civil defense program the major negative argument is that the devastation would be so enormous as to preclude any meaningful organized medical countermeasure activity. There are substantial numbers of individuals in the health professions who doubt the feasibility and/or the effectiveness of civil defense emergency health and medical operations. Much of this credibility problem stems from the fact that EHS plans have traditionally been inflexibly conceived within the standard framework of austere but traditional medical treatment concepts of mass casualty care. A second significant factor responsible for lack of credibility is that the plans have traditionally been developed by persons who are administratively outside of the state governments' everyday decision making apparatus. This has led to a wide variety of uncoordinated activity often resulting in unenforceable and unrealistic operational guidance.

A further issue which tends to confuse the overall EHS planning process is that existing plans for emergency health services in disaster, particularly those developed at the hospital or the community level, inordinately stress or completely limit themselves to the potential problems of natural disasters such as fires, floods, earthquakes, plane crashes, etc. The confusing factor is that it is widely held, even at the Federal level of preparedness planning, that community activities which increase this local operational capability to meet the increased demands of emergency health services in natural disaster will also increase the community's ability to cope with the medical aspects of nuclear attack operations in war time.

This direct relationship is not necessarily true. While some aspects of local preparedness to cope with medical aspects of natural disaster will definitely upgrade nuclear attack countermeasure capability, the bulk of such natural disaster preparedness has little or no bearing on the requirements in general war situations. Moreover, there are elements of natural disaster emergency plans which might actually reduce the community's capability to provide emergency health services in a nuclear attack environment. For example:

- *Plans for natural disasters usually call for:*
  - Immediate operational response
  - Concentration of medical resources
  - High medical and surgical standards
  - Availability of sufficient personnel and facilities
  - Availability of outside assistance
  - No substantive population relocation (with the exception of the Gulf Coast)
  - Pre-crisis local or areawide planning coordination
- *Plans for national disasters usually call for:*
  - Fallout radiation related operational constraints
  - Deferred operational response
  - Dispersion of medical resources
  - The most austere medical and surgical standards
  - Unavailability of sufficient personnel and facilities
  - Unavailability of meaningful outside assistance
  - Possibility of massive population relocation
  - National and state, as well as local and areawide, pre-crisis planning coordination

The distinction between the above is more than academic semantics. In actual practice when the same people are responsible for both, one is invariably stressed at the neglect of the other. A central issue in this project is to

identify the organization at national, state and local levels which should have the responsibility for national disaster planning. As Section II described, this activity in the past was clearly the responsibility of the Division of Emergency Health Services (DEHS) in the United States Public Health Service. Also as noted, however, the DEHS was abolished in the reorganization of 1974 and since that time the United States government has not maintained an adequately staffed organization charged with specific EHS planning and coordination activities. This clear lack of Federal interest has resulted in a similar erosion at the state and local level.

From the standpoint of preparedness to cope with medical aspects of nuclear warfare the most significant benefit of existing local plans for emergency health services in natural disaster is that these plans tend to foster a professional medical awareness of personal responsibility in disaster situations. Furthermore, they tend to establish within the medical and allied medical professions the concepts of command, control, and priority of activity during emergency operations. In essence, the most vital characteristic of a state or local emergency health service organization is the organization itself and not necessarily the plans it may have developed.

The central point is that rather than emphasizing a disaster plan per se what should be emphasized is the planning framework. Plans, at least in terms of their specific details and individually assigned responsibilities, quickly become out of date. The process is the important issue. This process and the individuals responsible for it are the same regardless of the disaster type. While specific natural disaster plans would be expected to differ from plans to cope with nuclear crisis situations the process within the state government, the people involved and the necessary inter- and intra-state coordination would be similar in most and identical in many instances.

Planning coordination is vital to the ultimate credibility of the plans and their successful operational application. States intending to significantly re-establish their EHS activities should ensure that the necessary coordination is enforced.

The necessity for improved statewide coordination is not of course limited to disaster planning. Federal government involvement at the state level in terms

of direct support for city programs, a variety of marketing opportunities, revenue sharing with the state government itself, and myriad other direct and indirect funding channels across all departments of the United States government have resulted in a greatly augmented state requirement to insure adequate coordination. This is best accomplished when the planning process is intimately associated with the routine decision process with particular reference to allocation of resources and legislative initiative. This process should exist within the existing decision making structure of the state government. It does not require alterations of normal command and control functions and it should not necessitate additional personnel. The key to to the successful planning process is coordination. The key to coordination is the creation of an administrative protocol which of and in itself fosters the necessary coordination between the appropriate offices and individuals. In addition to this necessary coordination, the successful EHS planning process must take place within an overall framework of state policy guidelines which are compatible with existing Federal policy and have the visible backing and support from the Office of the Governor.

EHS planning without the visible support of the Governor by definition cannot be credible. Probably the only realistic way to achieve this is for the chief of the EHS to report directly to the Governor and by integrating the emergency preparedness planning process with the routine activities of the various state agencies. This integration, however, is not without risk. The danger is that EHS priorities have a tendency to be downgraded and supplanted by activities intended to foster and support the state's capability to respond to the everyday requirements for emergency medical services as well as to the larger medical care demands resulting from natural disasters or large-scale accident situations. While this is a definite problem, a motivated state EHS director with the support of the Governor could insure that the EHS planning requirements are adequately represented.

B. EMERGENCY HEALTH SERVICE PLANNING REQUIREMENTS

This leads to the consideration of EHS planning requirements which can be thought of as being separated into three operational time phases.

- o Pre-emergency preparedness actions to be taken by the State Department of Health
- o Early post-attack operations of the Emergency Health Services organization
- o Long-range post-attack (recovery) operations of the Emergency Health Services organization

1. Pre-emergency preparedness actions

a. Objective

The first issue to be dealt with is the objective of the plan which must be considered in the context of the operative environmental situations which is nuclear attack upon the United States. The primary objective of an EHS system should be to provide the administrative framework by which the surviving medical resources within the state, including personnel, can be utilized most effectively. All elements of the plan should be in direct support of this objective.

b. Organization

An ad hoc Emergency Health Services Advisory Committee for planning the emergency organization should be convened by the Governor. The group should determine the existing organizational elements and health care programs currently operative within the state which can be utilized as the functional structure of the Emergency Health Services Organization. The committee acting with the director of the state EHS as appointed by the Governor should staff the EHS organization from within the existing state employment structure. The EHS group should then recommend the assignment of pre-emergency activity to select programs and organizations in order to train and test their

capability to perform their portion of the EHS mission. The resources and capabilities of State Health Systems Agencies and Emergency Medical Services organizations should be incorporated to the fullest extent possible.

c. Policy

Assuming the above objective to be operative, the state EHS plan should include a range of policy positions which if implemented will automatically have the force of an Emergency Order of the Governor. This requirement would vary somewhat from state to state but the basic issues which would need to be addressed by all states would include:

- o Allocation of Resources,
- o Expropriation of Private Medical Care Facilities,
- o Expropriation of Health Supplies and Equipment,
- o Control of all Health Manpower.

d. Civil Defense

The state health department should establish a closer working relationship with Civil Defense officials to develop the administrative procedures for common use of health resources under emergency conditions. To insure the most effective interdepartmental coordination during emergency operations, the operational headquarters of the EHS should be physically located within the State Emergency Operations Center (EOC). Duplicate copies of all essential EHS operating information and reference data should be prepositioned at the state's EHS/EOC and the material should be updated regularly.

e. Resources

The EHS system must have the capability to control the surviving resources so that allocation decisions in any given operating environment can be enforced. This resource control capability is the single most important element of the EHS system. It follows that effective resource control would be impossible without knowledge as to the

location and size of the resource inventory. Therefore, an extremely important element of the EHS plan is the documentation of the available resources and a capability to quickly assess the surviving resources in the event of attack. These resources in terms of manpower, facilities and supplies are outlined on Table VI-1.

Resource control cannot be over emphasized. Unless restriction on allocations are imposed, surviving medical resources would be exhausted very quickly. The indiscriminate and immediate deployment of the resources available to the EHS would result in an almost immediate nationwide shortage of everything and within days the total dissipation of many vital medical care supplies. The policy issue is that in certain potential situations the bulk of the surviving medical resources should be held in reserve and not deployed until such time post-attack that their application would be most effective in saving lives.

Unlike other emergency services such as fire and rescue, immediate intervention by the EHS would not always be the correct policy In operational terms, it has long been recognized that the great majority of injured persons who survive at least 24 hours will ultimately survive (this does not address the quality of survival) even without medical or surgical intervention. This does not apply of course to radiation injury but since in this case there is no practical emergency treatment the point is moot. Probably the single most effective medical intervention in terms of saving the greatest number of lives would be the control of infection (both radiation and trauma related) during the first few weeks post-attack. Since this position is generally accepted, holding a substantial pattern of the anti-infective agents in reserve is a logical step and should be reflected in the state's official policy guidance on the allocation of resources.

f. Emergency Directives

The state health department should develop draft emergency orders of the Governor that will facilitate the most efficient and effective

TABLE VI-1

HEALTH RESOURCES INFORMATION NEEDED FOR STATE EMERGENCY HEALTH SERVICES

TYPE OF HEALTH RESOURCE	USE OF DATA	SPECIFIC INFORMATION REQUIRED	SOURCES OF INFORMATION
Health Manpower	Basis for estimating availability of health manpower for emergency care and treatment of patients	Name, address, geographic location for - Physicians (by specialty) - Dentists - Nurses - Veteranarians - Pharmacists - Medical Students	Licensing Boards Medical Associations Professional Directory Hospitals Telephone Directories
Health Facilities	Basis for estimating availability of health facilities and supporting facilities for care and treatment of patients	Name, address, geographic location, bed capacities, personnel, services normally available, expansion potential, emergency supplies for - Emergency Medical Service Systems - General Hospitals - Special Hospitals *Mental, children, other* - Nursing Homes - Clinics - Dispensaries - Laboratories - Ambulatory Care Centers	State Hospital Assoc. Licensing Boards Medical Associations Directories Public Health Service
Health Supplies and Equipment	Basis for estimating availability of essential health supplies and equipment required during mobilization, survival and post-emergency periods	Name, address, geographic location, average inventories of producers, processors, wholesalers and retailers of - Pharmaceuticals *(particularly narcotics and antibiotics)* - Biologicals - Surgical textiles - Blood, blood collecting dispensing - Surgical instruments - Emergency surgical supplies	Trade Associations Directories Chamber of Commerce Field Survey

HEALTH RESOURCES INFORMATION NEEDED FOR STATE EMERGENCY HEALTH SERVICES

(continued)

TYPE OF HEALTH RESOURCE	USE OF DATA	SPECIFIC INFORMATION REQUIRED	SOURCES OF INFORMATION
Federal Health Facilities *(VA, DOD, PHS)*	Basis for estimating availability of health facilities and supporting facilities for care and treatment of patients. Overall support of environment health controls.	Name, address, geographic location of Federal hospitals, laboratories, communicable disease control points, supply depots, other special purpose facilities. Need data on beds, personnel, services available.	Veterans Administration Public Health Service Department of Defense

provision of health care services and control of health care resources during emergency operations. All state employees should be aware of their EHS duty assignments and their specific responsibilities within the established state alerting system. The overall state plan should be exercised on a regular basis for purposes of training, testing, evaluation and revision as appropriate.

g. Provide Guidance

The state health department should provide guidance to field health facilities and local governments in the development of plans for health personnel and facility protection and for emergency health care operations under various national or localized emergency conditions. This guidance should be provided through the appropriate individuals in the local health department to insure that the development of emergency plans are coordinated properly.

h. Mutual Aid

The state should develop mutual aid agreements with neighboring states as well as insuring that plans for intra-state emergency redistribution of health resources are kept current. All inter-state mutual aid agreements should be coordinated with regional and headquarters EHS personnel.

Working relationships should be established with appropriate state resources and claimant agencies to develop administrative procedures and techniques necessary to claim supporting services (transportation, etc.) and supplies needed by civilian medical facilities to carry out the state medical care mission in the post-emergency period.

Similar relationships should be established with appropriate Federal facilities located in the state (VA hospitals, PHS facilities, military hospitals) to develop policies and guidelines to facilitate effective utilization of facilities, equipment, medical supplies and personnel for the provision of medical care at the local level.

2. Early Post-Attack Operation of the EHS

In accordance with the standby plan the EHS organization is activated and prepares to assume full responsibility for emergency health services including the emergency management of health resources. The activities should include:

- o Activation of all appropriate health directives and standby plans dealing with health care and health care resources. All directives should be amended as appropriate as communication channels improve and more accurate information becomes available.

- o Evaluation of damage assessment intelligence (casualty counts--destruction of health facilities) as it becomes available. This will be a continuous operation subject to wide variation during early post-attack stages, but must be performed to:

  - estimate remaining hospital activity, health manpower and medical supply availability

  - estimate casualty care requirements and calculated rates of supply utilization

  - determine areas of potential health resources deficiency

  - make revision in original directives if conditions dictate

  - advise on requests for manpower and supply support

- o Issuing priority policy statements and statewide instructions for the controlled utilization and distribution of all health supplies including the emergency guidelines on the distribution of narcotics.

- o Preparation of time-phased estimates of requirements for essential health survival items, health material resources, health facilities and all other necessary supporting goods and services.

- o The direction of all intra-state movement of health resources including personnel, and the time-phased authorization of the delivery of direct emergency medical care at all levels by all health personnel within the state whether they be public employees or professionals in private practice.

3. Long-Range Post-Attack (Recovery) Operations of the Emergency Health Services Organization

The EHS organization should retain control of all health related activities until such time that the normal organizational structure of the state health department can cope with the existing requirements. Depending on the situation this time period could last up to and over one year post-attack. EHS post-attack activities would include:

- o Continuing control, evaluation, and redistribution of health resources and medical care delivery.
- o Provision of guidance or the assumption of major responsibilities in salvage and health care system reliabilitation programs which would include acting as the principal state advisor on intra-state claimancy actions dealing with proportionate share of existing or proportionate production of new medical supplies and facilities.
- o Maintenance of a central control for monitoring and investigating epidemic intelligence, radiation hazards, and health situation reports.
- o Provision of guidance and when appropriate, mandatory standards relevant to:
  - the rationing of health resources
  - casualty management
  - blood banks
  - physical rehabilitation services
  - substitute treatment techniques
  - alternate therapeutic agents
  - nutrition
  - mental health
  - vital statistics
  - inpatient admission policies
  - outpatient treatment standards
- o Advisory services in the re-establishment of public water supplies as well as the sanitation aspects of garbage collection and alternative sewerage facilities. Also, the provision of advice on disposal of the dead, decontamination, food and drug salvage procedures and all other relevent environmental public health services.

VII. CONCLUSIONS AND RECOMMENDATIONS

A. CONCLUSIONS

In terms of planning for the provision of Emergency Health Services in a nuclear crisis situation:

- o There is little or no current activity, at any level of government,
- o Meaningful military support to the civilian sector cannot be anticipated,
- o There is no significant health end item disaster reserve inventory.

B. RECOMMENDATIONS

It is recommended that:

- o The Defense Civil Preparedness Agency request that the United States Public Health Service review its Headquarters and Regional Emergency Health Services activities in terms of departmental compliance with Executive Order 11921 and its own internally developed policy and operational objectives.
- o The Defense Civil Preparedness Agency should examine the potential Civil Defense related impact of the:
  - Emergency Medical Services Systems Act of 1973 (EMSS),
  - Health Planning and Resource Development Act of 1974.
- o DCPA explore the possibility of providing Civil Defense related Emergency Health Services Research funds to one of the Centers for Study and Development of Health Planning established under the Health Planning and Resources Development Act of 1974.
- o Have DCPA (or successor FEMA) provide financial support to HSA's for areawide preparedness projects including plans, resource inventories and suggested operating procedures consistent with national policies, plans and guidelines.
- o The newly established Federal Emergency Management Agency include a strong mechanism to coordinate the Government-wide response to health and medical crisis situations.

- All health related Government interagency agreements be reviewed for current applicability.

- The Public Health Service strengthen its Regional EHS planning role and work closer with DCPA regional staff for the furtherance of coordinated disaster response at the state level.

- State EHS organizations be provided with guidance procedures and planning assumptions to upgrade their capability to determine requirements and assess availability of health resources in an emergency situation.

APPENDIX A

EMERGENCY HEALTH SERVICES

EMERGENCY HEALTH SERVICES

The purpose of this chapter is to describe the organization, functions, staffing and general administration of the Emergency Health Service (EHS). The overall mission of the EHS is to assist State health agencies in meeting the health needs of the civilian population during a national emergency. The majority of the direct operations of the EHS would be conducted by the Regional EHS working with the States and under policy control and guidance from headquarters. This chapter supplements the Department of Health, Education, and Welfare Emergency Manual, describes operations that must be centralized and provide the basis for development of a viable, coordinated Regional EHS plan and organization.

MATERIAL TRANSMITTED

Chapter PHS: 2-10, Planning, Pages 1-2.
Exhibit PHS: X2-10-1, Categorization of Emergency Responsibilities, 1 Page.
Exhibit PHS: X2-10-2, Plans Content, 1 Page.
Chapter PHS: 2-90, PHS Emergency Operating Center (EOC), 1 Page.
Exhibit PHS: X2-90-1, PHS Emergency Operating Center (EOC), 1 Page.
Exhibit PHS: X2-140-1, DMO 8540.1 Health Manpower Occupations, Pages 1-2.
Chapter PHS: 3-00, Increased Readiness Actions, 1 Page.
Exhibit PHS: X3-00-1, "Initial Alert" - PHS Actions, 1 Page.
Exhibit PHS: X3-00-2, "Initial Alert" - PHS Agency Actions, 1 Page.
Exhibit PHS: X3-00-3, "Initial Alert" - Individual Actions, 1 Page.
Exhibit PHS: X3-10-1, "Advanced Alert" - PHS Actions, 1 Page.
Exhibit PHS: X3-10-2, "Advanced Alert" - PHS Agency Actions, 1 Page.
Exhibit PHS: X3-10-3, "Advanced Alert" - Individual Actions, 1 Page.
Chapter PHS: 4-40, Emergency Health Service, Pages 1-5.
Exhibit PHS: X4-40-1, Emergency Health Service Organization Chart, 1 Page.
Chapter PHS: 4-42, Bureau of Health Operations, Pages 1-3.
Exhibit PHS: X4-42-1, Bureau of Health Operations Organization Chart, 1 Page.
Chapter PHS: 4-43, Bureau of Health Manpower, Emergency Health Service, Pages 1-4.
Exhibit PHS: X4-43-1, Bureau of Health Manpower Organization Chart, 1 Page.
Chapter PHS: 4-44, Bureau of Health Materiel, Emergency Health Service, Pages 1-8.
Exhibit PHS: X4-44-1, Bureau of Health Materiel Organization Chart, 1 Page.
Chapter PHS: 6-00, Emergency Operation of PHS Field Facilities Not Assigned a Federal Mission, Pages 1-2.
Chapter PHS: 6-10, Federal Mission Assignments - PHS Field Facilities, 1 Page.

MATERIAL SUPERSEDED

Chapter HSM: 2-10 (HSM TN-72.1, 4/1/72), Pages 1-2.
Exhibit HSM: X2-10-1 (HSM TN-72.1, 4/1/72), 1 Page.
Exhibit HSM: X2-40-1 (HSM TN-72.1, 4/1/72), 1 Page.
Exhibit HSM: X3-10-1 (HSM TN-72.1, 4/1/72), 1 Page.
Exhibit HSM: X3-10-2 (HSM TN-72.1, 4/1/72), 1 Page.
Chapter HSM: 4-40 (HSM TN-72.1, 4/1/72), Pages 1-5.
Exhibit HSM: 4-40-1 (HSM TN-72.1, 4/1/72), 1 Page.
Chapter HSM: 4-42 (HSM TN-72.1, 4/1/72), Pages 1-3.
Exhibit HSM: X4-42-1 (HSM TN-72.1, 4/1/72), 1 Page.
Chapter HSM: 4-43 (HSM TN-72.1, 4/1/72), Pages 1-4.
Exhibit HSM: X4-43-1 (HSM TN-72.1, 4/1/72), 1 Page.

Distribution: MS.HRFC-h (OASH, ADAMHA, CDC, FDA, HRA, HSA, and NIH Addressees Plus Regional Directors' Staff Only)

CHAPTER PHS: 2-10

PLANNING

PHS:
2-10-00 PURPOSE AND SCOPE

This chapter supplements HEW Emergency Manual Chapter 2-10 and expands the scope to include PHS field installations not assigned a Federal mission. (See Chapters PHS: 6-00 and PHS: 6-10 for emergency mission assignments.)

PHS:
2-10-10 GENERAL REQUIREMENTS

A. Written Plan. Each PHS facility officer in charge shall develop an emergency operations plan which may be combined with facility natural disaster plans and facility protection plans, if any. See Exhibit PHS: X2-10-2 for "Plans Content" applicable to all facilities, except the Center for Disease Control which has a Federal mission and a more comprehensive plan (see Chapter PHS: 4-42).

B. Plans Issuance. A copy of the emergency plan should be distributed to each employee of the facility and to other persons having assignments with the facility (e.g., Social Security Administration District Office employees, volunteers). Each new employee should receive a copy of the plan when he enters on duty. Copies shall be sent to State or local civil defense directors as appropriate, Regional Health Administrators, and Office of Administrative Management, PHS.

PHS:
2-10-20 SPECIAL REQUIREMENTS

B. Specified Field Facilities

1. Field Facilities with Federal Mission. Field facilities assigned a Federal postattack mission (see Chapter PHS: 6-10), shall follow planning guidance in HEW Emergency Manual Chapter 2-10.

2. Field Facilities with State or Local Mission. Field facilities whose postattack mission is the support of State or local government emergency health activities shall fully coordinate their plans with those of the appropriate governmental civil defense agency. Overall plans shall include postattack provision of services by the facility and provision by the governmental agency of supplies and supporting services to the facility (see Chapter PHS: 6-00).

The following determinations are made in accordance with policy requirements referred to or stated in paragraph 2-10-20C of the HEW Emergency Manual:

CATEGORY	ORGANIZATION
"A"	PUBLIC HEALTH SERVICE OFFICE OF THE ASSISTANT SECRETARY FOR HEALTH ALCOHOL, DRUG ABUSE, AND MENTAL HEALTH ADMINISTRATION CENTER FOR DISEASE CONTROL FOOD AND DRUG ADMINISTRATION HEALTH RESOURCES ADMINISTRATION HEALTH SERVICES ADMINISTRATION
"B"	NONE
"C"	NATIONAL INSTITUTES OF HEALTH

The content of plans will vary according to the type and location of installation and its local or State emergency mission. While a standard format and arrangement of contents is not required for all types of installations, there are certain subjects which must be dealt with in each plan. The following primary and secondary subject headings are recommended:

Purpose of the Plan
Planning Assumptions (Anticipated Postattack Situation)
  Damage (to structures, utilities, personnel, communications)
  Fallout (severity and duration)
Emergency Mission (days are approximated)
  D-Day to D+14 (fallout pindown period)
  D+14 to D+30 (local action period)
  D+30 and until recalled to Federal Services
Emergency Organization and Functions
Order of Succession
Staffing Assignments and Current Roster
Alerting System
Facility Protection (see Chapter 2-80)
Relocation Plan
Vital Operating Records
Coordination with State or Local Plans
  (to include sources of supply and supporting services)
Increase-Readiness Actions
Activation

CHAPTER PHS: 2-90

PHS EMERGENCY OPERATING CENTER (EOC)

PHS:
2-90-00 PURPOSE

The policies, procedures, and requirements contained in the HEW Emergency Manual, Chapter 2-90, shall apply to the Public Health Service (PHS).

PHS:
2-90-60 PHS EMERGENCY OPERATING CENTER

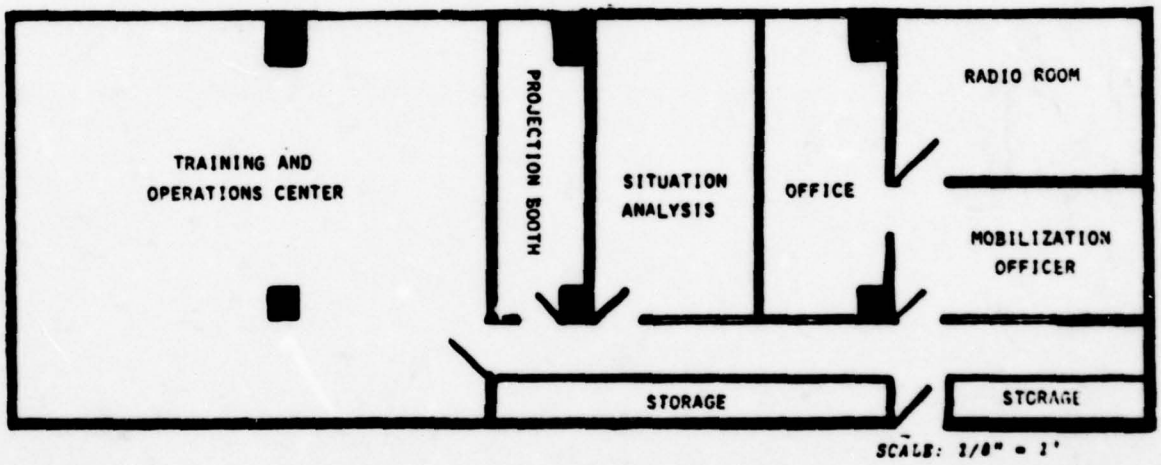
A. Office of the Assistant Secretary for Health, Parklawn Building, Rockville, Maryland.

1. General. The Emergency Preparedness Staff, Office of Administrative Management/PHS, maintains the Assistant Secretary for Health's EOC for use by Category "A" PHS components in the Rockville, Maryland area.

2. Parklawn Building EOC. The Assistant Secretary for Health's primary EOC is located in Room 4-81, contains approximately 2,200 sq. ft. of usable floor space, has a rated occupancy of 25 persons (PHS Team "A"), and meets minimal Federal requirements for an EOC. See Exhibit PHS: X2-90-1 for floor plan.

EMERGENCY OPERATING CENTER

ROOM 4-81 PARKLAWN BUILDING - 5600 FISHERS LANE - ROCKVILLE, MARYLAND 20857



SCALE: 1/8" = 1'

Title 32A—NATIONAL DEFENSE, APPENDIX

Chapter I—Office of Emergency Planning

[Defense Mobilization Order 8540.1]

DMO 8540.1—HEALTH MANPOWER OCCUPATIONS

1. *Purpose and authority.* This Order issues the List of Health Manpower Occupations in accordance with the authority contained in Executive Order No. 11001, dated February 16, 1962 (27 F.R. 1534), which assigns to the Secretary of Health, Education, and Welfare, emergency preparedness functions to include development of preparedness programs covering civilian health manpower. It provides further for the issuance of the List of Health Manpower Occupations by the Director of the Office of Emergency Planning after agreement by the Secretary of Labor and the Secretary of Health, Education, and Welfare.

2. *Definitions.* Executive Order No. 11001 defines health manpower as "physicians (including osteopaths), dentists, sanitary engineers, registered professional nurses; and such other occupations as may be included in the List of Health Manpower Occupations."

3. *Responsibilities.* Executive Orders No. 11000 and No. 11001 assign civilian manpower mobilization planning responsibilities to the Department of Labor and civilian health manpower mobilization planning responsibilities to the Department of Health, Education, and Welfare.

The Department of Health, Education, and Welfare, therefore, and appropriate State and local health officials have the primary responsibility for planning the organization, training, and utilization of civilian health manpower. The facilities of the Department of Labor and its affiliated State employment agencies will be utilized in carrying out the health program (e.g., recruitment, referral, and other manpower measures).

The skills identified in the attached List of Health Manpower Occupations are those which will be immediately required for the provision of essential emergency public health and medical services. Persons possessing the listed skills and allocated by appropriate officials to meet nonmilitary requirements will be made available to health services. However, as health hazards are brought under control and medical care loads permit, health officials will release for utilization in other essential activities the health manpower that is no longer critically needed. Following the post-attack period, during which survival of the population is the pre-eminent consideration, Federal health and manpower officials will review the List and make recommendations to the Director of the Office of Emergency Planning for appropriate revisions.

Supporting manpower, integral to health operations, e.g., hospital, sanitation, and laboratory helpers, and engineering, clerical, food service and custodial personnel, is not listed. Such civilian manpower employed at the time of attack by a medical facility or laboratory, or governmental health agency, will, if not ordered to military service, remain with the employing organization. All others will be provided according to priorities established by the manpower agency or ranking governmental official.

4. *Effective date.* This Order is effective the date of issuance.

Dated: March 11, 1964.

EDWARD A. MCDERMOTT,
Director,
Office of Emergency Planning.

(Approved March 1968 for the Master D.O.T File but not published)

[F.R. Doc. 64-2509; Filed, Mar. 17, 1964; 8:46 a.m.]

Amendment of List

Pursuant to Executive Order No. 11001, a list of health manpower occupations was prepared in the Department of Labor and the Department of Health, Education, and Welfare and was issued by the Director of the Office of Emergency Planning as an annex to Defense Mobilization Order 8540.1 on March 11, 1964 (29 F.R. 3474; 32A CFR, Chap. I). That list identified health manpower occupations in terms of occupational titles and code numbers appearing in the second edition of the Dictionary of Occupational Titles of the Department of Labor. Since that time the Department of Labor has issued a third edition of that dictionary. The list published herewith reflects health manpower occupational titles and code numbers appearing in the third edition of the dictionary, and supersedes the list published as an annex to DMO 8540.1 in 29 F.R. 3474 on March 18, 1964. No textural changes in DMO 8540.1 are being made. The occupational titles used in the list published herewith were selected on the basis that they are the same as, or the equivalent of, titles in the existing list. To make the list more useful, certain alternate or related titles have been included but this has been done on a selective basis in order to keep the list as concise as possible and to avoid repetitive terminology. The skills identified in the List of Health Manpower Occupations set forth below are those which will be immediately required for the provision of essential emergency public health and medical services.

Dated: March 14, 1968.

PRICE DANIEL,
Director,
Office of Emergency Planning.

CHAPTER PHS: 3-00

INCREASED READINESS ACTIONS

PHS:
3-00-00 PURPOSE

This chapter prescribes PHS actions which shall be taken upon receipt of an Increased Readiness or Attack Warning Condition. It is applicable to all PHS headquarters and PHS Regional Offices, officers in charge at alternate emergency operating facilities, and employees having emergency duty assignments. This chapter is to be used in conjunction with the corresponding HEW Chapter.

PHS:
3-00-30 READINESS LEVELS

B. Initial Alert. Upon official notification, the PHS Emergency Operating Center (EOC) and the EOCs established by CDC and NIH shall be manned (see HEW Chapter 2-90) and corrective action taken to overcome any deficiencies in PHS emergency plans and procedures. A 24-hour communications watch shall be established. PHS agency EOCs shall be established by CDC and NIH, but manning shall be limited to team "A" members required for maintenance of a 24-hour communications watch. Actions will be carried out with minimum disclosure. For details of these actions, see the following exhibits to this chapter:

PHS: X3-00-1 Emergency Coordinator/PHS
PHS: X3-00-2 Heads of PHS Operating Agencies
ATTN: Emergency Coordinators
PHS: X3-00-3 All PHS Headquarters
Emergency Duty Assignees

C. Advanced Alert. All PHS agency headquarters EOCs will be manned by respective teams "A" and a 24-hour communications watch will be maintained at each location. Members of PHS headquarters and regional teams "B" and members of headquarters team "C" will prepare to relocate. For details of these actions, see the following exhibits:

PHS: X3-10-1 Emergency Coordinator/PHS
PHS: X3-10-2 Heads of PHS Operating Agencies
ATTN: Emergency Coordinators
PHS: X3-10-3 All PHS Headquarters
Emergency Duty Assignees

MEMORANDUM

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE
Public Health Service

TO : Emergency Coordinator/PHS

DATE: JUN 2 1 1977

EAD
PHS:IA-1

FROM : Director
Office of Administrative Management

SUBJECT: INITIAL ALERT - Emergency Actions

The following actions shall be accomplished immediately upon receipt of notification of an "Initial Alert" Increased Readiness Condition:

Action No.	Description of Action
1.	Notify staff members of increased readiness condition.
2.	Activate PHS headquarters alerting network.
3.	Establish duty rosters of 24-hour continuous manning of office.
4.	Establish duty roster for manning the Assistant Secretary for Health's Parklawn Emergency Operating Center from the "A" team cadre.
5.	Maintain continuous monitoring of all communications systems.
6.	Provide refresher training to staff members for operation of all communications systems.
7.	Request temporary detail of additional support personnel.
8.	Review adequacy of emergency readiness plans and procedures, identify and correct deficiencies.

BY ORDER OF THE ASSISTANT SECRETARY FOR HEALTH

John C. Drake

Director
Office of Administrative Management

MEMORANDUM

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE
Public Health Service

TO : Heads of PHS Operating Agencies
ATTN: Emergency Coordinators

DATE: JUN 21 1977

EAD
PHS: IA-2

FROM : Director
Office of Administrative Management

SUBJECT: INITIAL ALERT - Emergency Actions

The following actions shall be accomplished immediately upon receipt of notification of an "Initial Alert" Increased Readiness Condition:

Action No.	Description of Action
1.	Activate alerting network for your PHS agency (emergency duty assignees only).
2.	Review emergency duty rosters and fill vacancies. Cancel travel orders of emergency assignees and recall to duty those on leave or in travel status.
3.	Arrange the release from regular duty any personnel designated to staff the Assistant Secretary for Health's Parklawn Emergency Operating Center (EOC), and the EOC's established by CDC and NIH.
4.	Participate in special briefings called by the Assistant Secretary for Health or the Directors of CDC and NIH.
5.	Keep agency head informed of any developments.
6.	Inspect alternate emergency operating facilities, if any.
7.	Arrange for the preparation of travel orders of emergency assignees who would relocate.
8.	Submit daily readiness status report to the Emergency Coordinator, PHS.
9.	Provide vital operating records to your Emergency Coordinator for transfer to alternate operating facilities.

BY ORDER OF THE ASSISTANT SECRETARY FOR HEALTH

John C. Brooks

Director
Office of Administrative Management

MEMORANDUM

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE
Public Health Service

TO : All PHS Headquarters Emergency Duty Assignees

DATE: JUN 2 1 1977

EAD
PHS: 1A-5

FROM : Director
Office of Administrative Management

SUBJECT: INITIAL ALERT - Emergency Actions

The following actions shall be accomplished immediately upon your receipt of notification of an "Initial Alert" Increased Readiness Condition:

Action No.	Description of Action
1.	Repeat the alerting message verbatim to the caller; obtain his confirmation that message is correct. Do not request clarification or additional information.
2.	Referring to your copy of the emergency alerting diagram, call any persons named immediately below you in the cascade network, and relay the alert message verbatim.
3.	If you can not contact a person (or his alternate, if any), you must call the persons he would have called. THE CALL DOWN CHAIN MUST NOT BE BROKEN.
4.	Keep the person above you on the alerting diagram informed of your whereabouts when away from home or office.
5.	Review and test your family survival plan.
6.	Stand by for individual instructions or a subsequent increased-alert condition.
7.	Participate in any meetings or briefings called by the Emergency Coordinator, PHS.

BY ORDER OF THE ASSISTANT SECRETARY FOR HEALTH

John C Drake

Director
Office of Administrative Management

MEMORANDUM

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE
Public Health Service

TO : Emergency Coordinator, PHS

DATE: JUN 2 1 1977

EAD
PHS:AA-1

FROM : Director
Office of Administrative Management

SUBJECT: ADVANCED ALERT - Emergency Actions

The following actions shall be accomplished immediately upon receipt of notification of an "Advanced Alert" Increased Readiness Condition:

Action No.	Description of Action
1.	Notify your staff members of increased readiness condition.
2.	Activate PHS headquarters alerting network.
3.	Activate the Assistant Secretary for Health's Parklawn Emergency Operating Center (EOC).
4.	Direct "A" team members to report to the Parklawn EOC; establish 24-hour continuous duty roster.
5.	Maintain continuous monitoring of all communications systems.
6.	Provide refresher training to staff members on operation of radios and other equipment.
7.	Request temporary detail of additional support personnel, as required.
8.	Review adequacy of emergency readiness plans and correct deficiencies.
9.	Direct individual emergency duty assignees to prepare for mobilization and assignments.
10.	Inform the Assistant Secretary for Health and Emergency Coordinator, HEW, of readiness status.

BY ORDER OF THE ASSISTANT SECRETARY FOR HEALTH

John C Drake

Director
Office of Administrative Management

MEMORANDUM

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE
Public Health Service

TO : Heads of PHS Operating Agencies
ATTN: Emergency Coordinators

DATE: JUN 21 1977

EAD
PHS: IA-2

FROM : Director
Office of Administrative Management

SUBJECT: INITIAL ALERT - Emergency Actions

The following actions shall be accomplished immediately upon receipt of notification of an "Initial Alert" Increased Readiness Condition:

Action No.	Description of Action
1.	Activate alerting network for your PHS agency (emergency duty assignees only).
2.	Review emergency duty rosters and fill vacancies. Cancel travel orders of emergency assignees and recall to duty those on leave or in travel status.
3.	Arrange the release from regular duty any personnel designated to staff the Assistant Secretary for Health's Parklawn Emergency Operating Center (EOC), and the EOC's established by CDC and NIH.
4.	Participate in special briefings called by the Assistant Secretary for Health or the Directors of CDC and NIH.
5.	Keep agency head informed of any developments.
6.	Inspect alternate emergency operating facilities, if any.
7.	Arrange for the preparation of travel orders of emergency assignees who would relocate.
8.	Submit daily readiness status report to the Emergency Coordinator, PHS.
9.	Provide vital operating records to your Emergency Coordinator for transfer to alternate operating facilities.

BY ORDER OF THE ASSISTANT SECRETARY FOR HEALTH

John C. Drake

Director
Office of Administrative Management

MEMORANDUM

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE
Public Health Service

TO : All PHS Headquarters
Emergency Duty Assignees

DATE: June 21, 1977

EAD
PHS: AA-5

FROM : Director
Office of Administrative Management

SUBJECT: ADVANCED ALERT - Emergency Actions

The following actions shall be accomplished immediately upon receipt of notification of an "Advanced Alert" Increased Readiness Condition:

Action No.	Description of Action
1.	Repeat the alerting message verbatim to the caller; obtain his confirmation that message is correct. Do not request clarification or additional information.
2.	Referring to your copy of the emergency alerting diagram, call any persons named immediately below you in the cascade network, and relay the alert message verbatim.
3.	If you can not contact a person (or his alternate, if any), you must call the persons he would have called. THE CHAIN MUST NOT BE BROKEN.
4.	Make arrangements for your family's protection and safety.
5.	Keep the person above you on the alerting diagram informed of your whereabouts when away from home or office.
6.	Stand by for individual instructions on relocation or attack warnings.
7.	Participate in any meetings or briefings called by the Emergency Coordinator, PHS.
8.	Cancel your travel or leave plans.
9.	Obtain a travel order if you have a relocation assignment.
10.	Assemble personal kit of subsistence and survival items.
11.	If you have a relocation assignment, fill your gas tank and prepare for relocation.
12.	If you are a member of Team "A", complete your calls as required to the others on the call down cascade alerting system and report immediately to your assigned emergency duty location, i.e., Parklawn Emergency Operating Center and the EOC established by NIH.

BY ORDER OF THE ASSISTANT SECRETARY FOR HEALTH

John C Drake

Director
Office of Administrative Management

CHAPTER PHS: 4-40

EMERGENCY HEALTH SERVICE

PHS:
4-40-00 PURPOSE

The purpose of this chapter is to describe the organization, functions, staffing, and general administration of the Emergency Health Service (EHS) which is established pursuant to the authorities set forth in Sections 102(b) and 3008 of the Executive Order (E.O.) 11490, as amended by E.O. 11921; and the HEW Emergency Manual, Part 4. It is primarily for the use and information of personnel with emergency relocation assignment to EHS and/or responsibility for emergency health program planning. The majority of the direct operations of EHS shall be conducted by the Regional EHS Offices working with the States and under policy control and guidance from headquarters. This chapter describes operations which must necessarily be centralized. (See DHEW Chapter 4-00, section 4-00-50.)

PHS:
4-40-10 OBJECTIVE

The overall objective and mission of EHS will be to assist State health agencies in meeting the health needs of the civilian population during a national emergency through: mobilization and effective utilization of health resources for the provision of health services including, when necessary, re-establishment or augmentation of State and local health services; maintenance of the health of the surviving uninjured population; and physical and mental rehabilitation to assure the productive capacity of the greatest possible number of disabled people.

PHS:
4-40-20 ORGANIZATION

At D plus 14 days (D+14), EHS shall be composed of the Office of the Chief, a General Planning Staff, and three bureaus: Bureau of Health Operations, Bureau of Health Manpower, and Bureau of Health Materiel. (See Exhibit PHS: X4-40-1.) Prior to D+14, the small size of the EHS cadre will not warrant establishment of subunits.

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EMERGENCY HEALTH SERVICES IN A NUCLEAR ATTACK ENVIRONMENT.(U)
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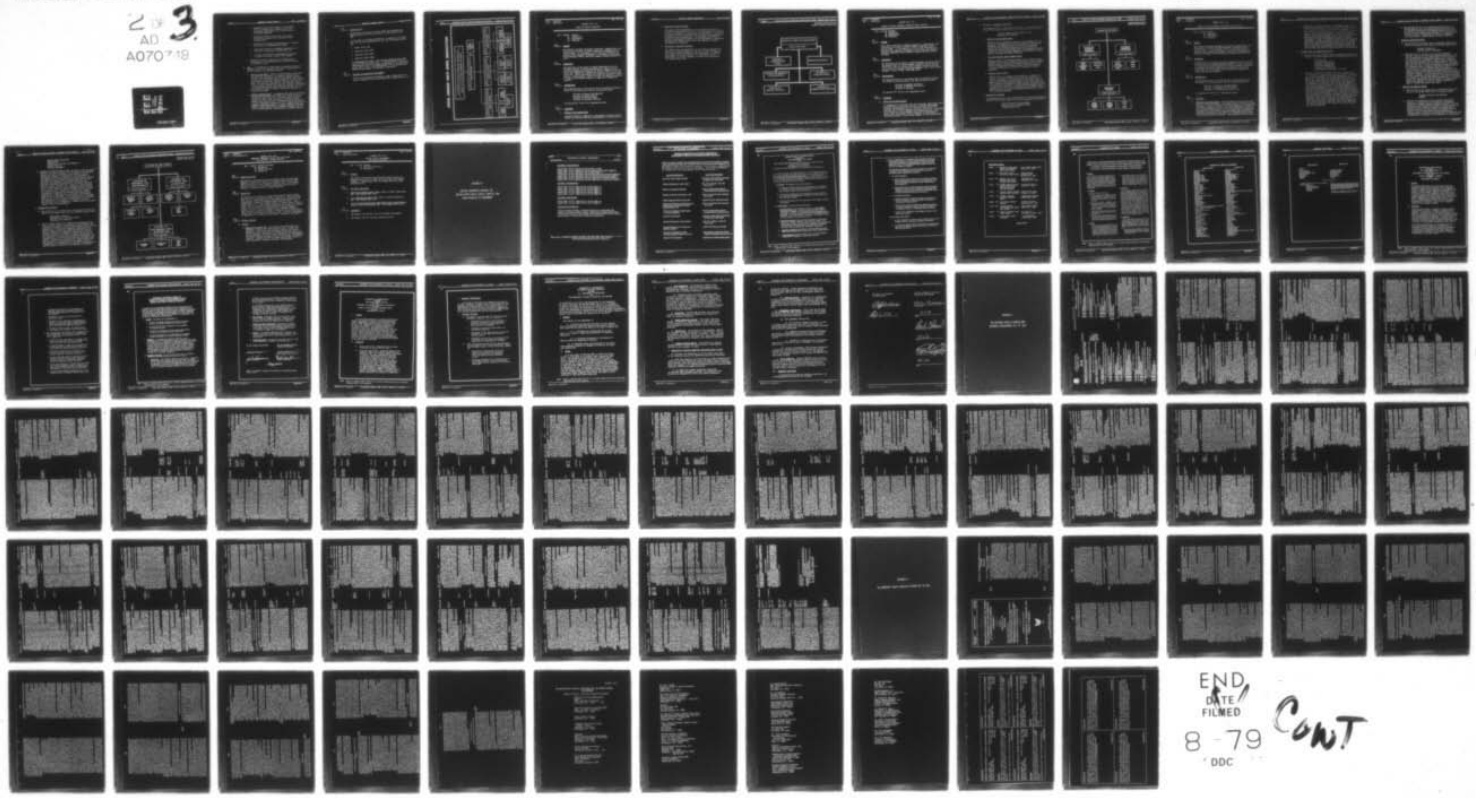

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CONT

b. Claimancy based upon estimates of requirements and in accordance with claimancy policy and procedures established by the various resource controlling agencies;

c. EHS program policy and decision formulation, direction, and execution of emergency health program plans;

d. Provision of guidance and consultation to regional EHS offices, as communications permit;

e. Review and revision of emergency program plans in the light of postattack circumstances; and

f. Issuance of nationwide announcements pertaining to health situations, hazards, and defenses.

5. Expansion function: preparation of administrative arrangements and briefing materials for EHS personnel as recalled to duty.

B. D+14. In accordance with DHEW plans for gradual build-up of emergency staffs, the Bureaus of EHS will be established at D+14 to perform the following functions:

1. Office of the Chief - Directs the activities of EHS, with the advice and assistance of a general planning staff, special staff assistants, and advisory bodies; maintains contacts and coordinates Bureau contacts with other Federal departments and agencies, regional offices, State governments, professional organizations, and voluntary organizations on health program policy matters; maintains intelligence on international health operations and problems; and provides administrative and public information services not available from DHEW.

2. General Planning Staff - Coordinates EHS planning activities and assures conformance with DHEW and national policies; evaluates nature and extent of national health problems; advises the Chief, EHS, on matters of general program emphasis and overall policy; recommends program and organizational adjustments necessary to meet changing emergency ne suggests legislation needed to support program activities; advises on the continuation of emergency programs and init tion of rehabilitation, reconstruction, research, educatio

PHS:
4-40-40 ADMINISTRATION

The Assistant Secretary for Health (ASH) has designated the Deputy Assistant Secretary for Health to serve as the Chief, EHS.

In the event of the death, disability, or absence of the Chief, EHS, the ASH has established that the line of succession shall be:

1. Deputy Chief, EHS

2. Associate Chief (HSA)

3. Associate Chief (FDA)

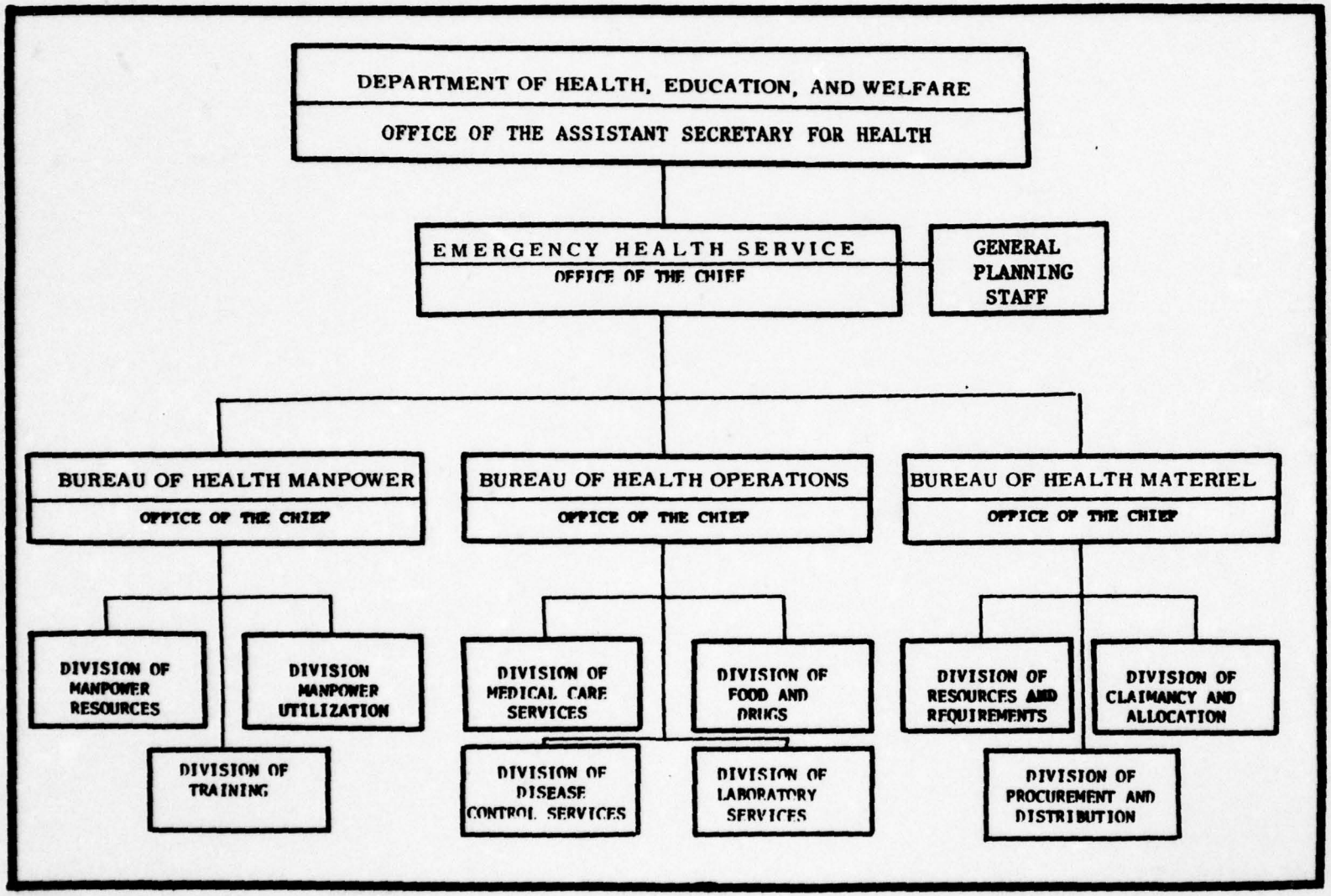
4. Associate Chief (HRA)

A predesignated official of the Veterans Administration shall serve as "Associate Chief, EHS." Provision shall be made for representation by other cooperating agencies at the appropriate policy level of EHS. (See DHEW Chapter 1-70 for policies and procedures pertaining to interagency cooperation.)

PHS:
4-40-50 STAFFING AND RELOCATION ASSIGNMENTS

Policies and procedures pertaining to EHS staffing and relocation assignments follow those described in DHEW Chapter 2-30.

FEDERAL EMERGENCY HEALTH SERVICE ORGANIZATION



rgency EMERGENCY HEALTH SERVICE ORGANIZATION CHART Exhibit PHS: X4-40-1

CHAPTER PHS: 4-42

BUREAU OF HEALTH OPERATIONS

PHS:
4-42-00 **PURPOSE**

This chapter describes the general objectives, organization, and functions of the Bureau of Health Operations, Emergency Health Service (EHS). It is primarily for the use and information of personnel with emergency assignment to the Bureau and personnel having emergency health operations program planning responsibilities.

PHS:
4-42-10 **OBJECTIVES**

The objectives of the Bureau of Health Operations will be to determine national civilian requirements for health services, and provide operational guidance and conduct programs to aid the States and communities in meeting the needs of the civilian population for: health and medical care, physical and mental rehabilitation, disease control, safety of foods, and safety and potency of drugs and biologicals produced or imported for human consumption.

PHS:
4-42-20 **ORGANIZATION**

The responsibilities of the Bureau will be exercised through the Office of the Bureau Chief and the following divisions:

Division of Medical Care Services
Division of Disease Control
Division of Food and Drugs
Division of Laboratory Services

See Exhibit PHS: X4-42-1 for organization chart.

PHS:
4-42-30 **FUNCTIONS**

A. **Office of the Bureau Chief**

Provides direction, supervision, and guidance to assure coordination and effective planning, implementation, and evaluation of

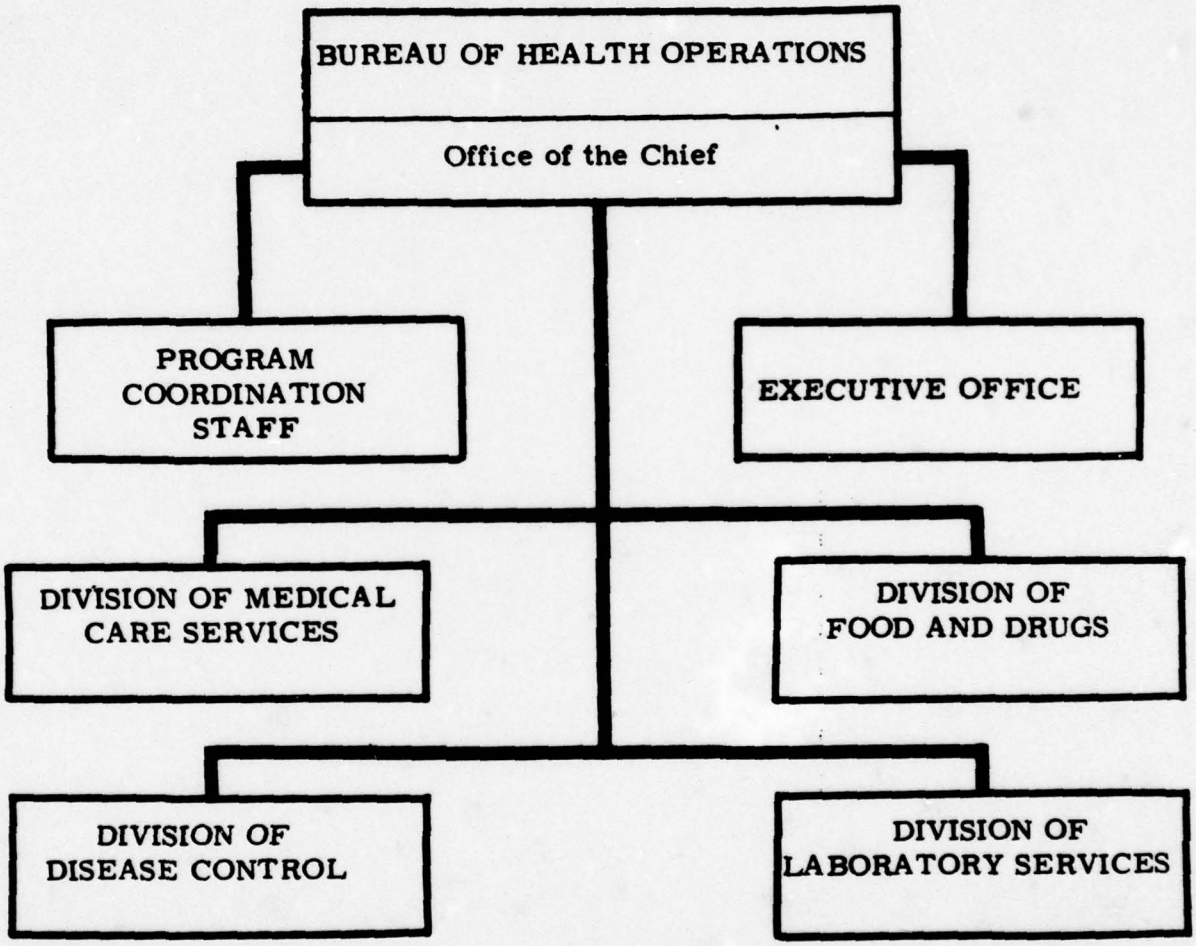
D. Division of Food and Drugs

This Division has responsibility for the Bureau's programs and activities concerned with safety in the processing or distribution of food, and production, processing, or distribution of drugs and biologicals (except in specific areas for which the Department of Agriculture has responsibility). It maintains liaison and co-operative working relationships with the Department of Agriculture and with other Federal, State, and local agencies to assure coordination of interests.

E. Division of Laboratory Services

This Division has responsibility for the Bureau's programs and activities concerning laboratory services to meet the needs of all civilian health programs and the coordination of programs under public or private auspices to provide blood, blood derivatives, and volume expanders, to meet blood requirements for civilian population.

Emergency Health Service
Bureau of Health Operations



CHAPTER PHS: 4-43

BUREAU OF HEALTH MANPOWER, EMERGENCY HEALTH SERVICE

PHS:
4-43-00 PURPOSE

This chapter describes the general objectives, organization, and functions of the Bureau of Health Manpower, Emergency Health Service (EHS). It is primarily for the use and information of personnel with emergency assignment to the Bureau and personnel having pre-emergency health manpower program planning responsibilities.

PHS:
4-43-10 OBJECTIVES

The objectives of the Bureau of Health Manpower will be to insure the maximum number of health manpower equitably distributed and effectively used; to increase health manpower resources through the provision of adequate supporting manpower; and to train health manpower in order to meet long-range needs.

PHS:
4-43-20 ORGANIZATION

The responsibilities of this Bureau shall be exercised through the Office of the Bureau Chief, and the following Divisions:

Division of Manpower Resources
Division of Manpower Utilization
Division of Training

See Exhibit PHS: X4-43-1 for organization chart.

PHS:
4-43-30 FUNCTIONS

A. Office of the Bureau Chief

Is responsible to the Chief, EHS, for directing, supervising, and evaluating Bureau activities in order to provide the program, policies, and guidelines for the equitable distribution and effective use of health manpower and supporting skills; coordinates the carrying out of the program through other agencies at the State, local, and Federal levels; develops and coordinates a nationwide program to train health manpower in both professional

C. Division of Manpower Utilization

The responsibilities of the Division shall be exercised through the Office of the Division Chief and the following operating branches:

Civilian Manpower Apportionment Branch
Reserve Forces Branch

1. Office of the Division Chief

Provides overall planning, direction, and coordination of the Division's programs and activities; coordinates and provides management and administrative services for all programs; directs and coordinates Division activities carried out through the regional EHS organization; and maintains relationships with other Government agencies and professional organizations concerned with health manpower.

2. Civilian Manpower Apportionment Branch

Advises on and, as authorized, directs most effective interregional distribution of manpower resources to meet the health program needs of the Bureau of Health Operations; and works with the Transportation Branch, Bureau of Health Materiel, to secure appropriate priorities for transport of health personnel.

3. Reserve Forces Branch

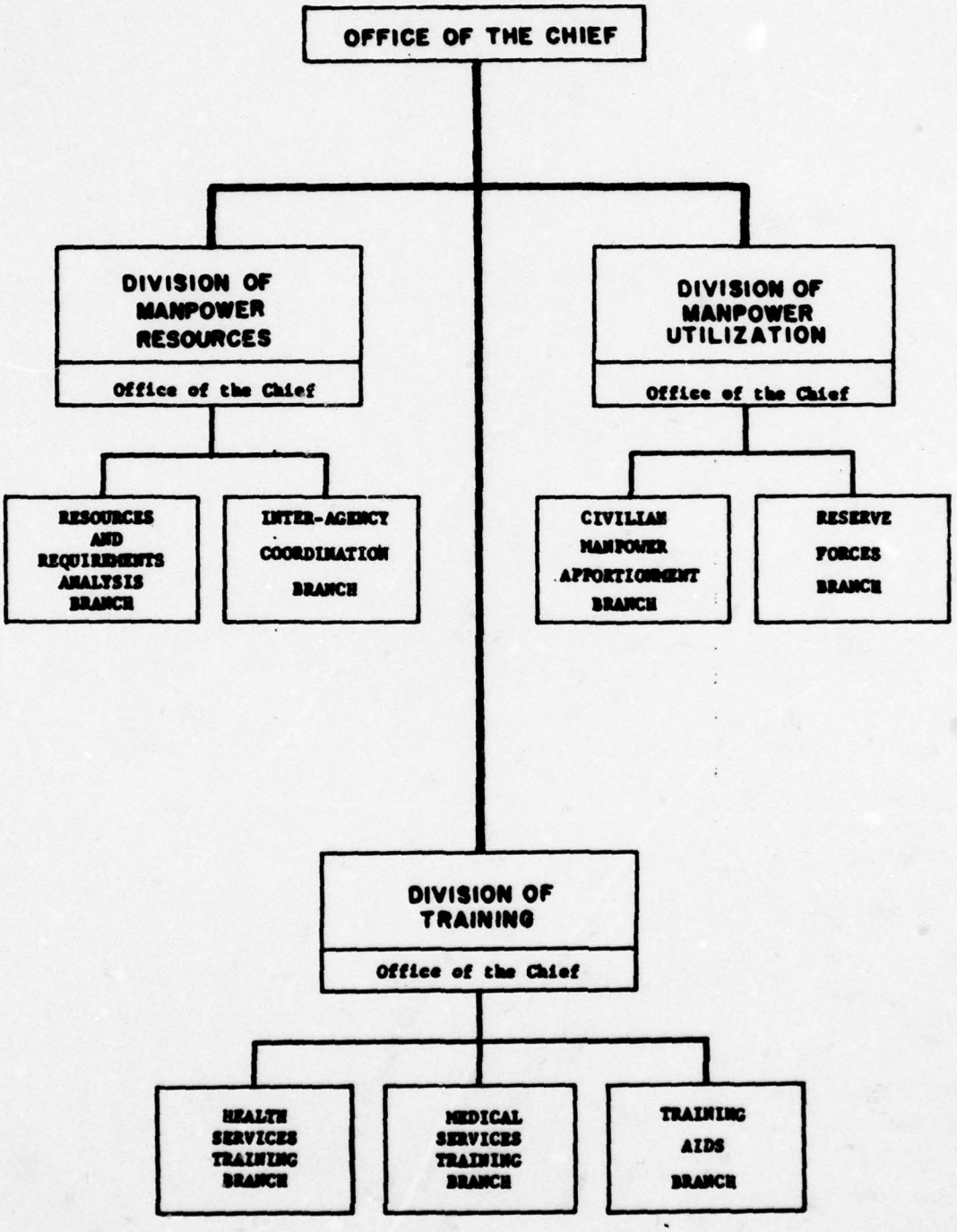
Maintains data on strength and distribution of regular and reserve (including activated reservist) PHS Commissioned officers assigned to and comprising the State and local commands (units) within regions; advises on and, as authorized, makes equitable distribution between regions and details units, or specialists from units, to meet specified emergency health situations; and works with the Transportation Branch, Bureau of Health Materiel, to secure appropriate priorities for transport of health personnel.

D. Division of Training

The responsibilities of the Division shall be exercised through the Office of the Division Chief and the following operating branches:

Health Services Training Branch
Medical Services Training Branch
Training Aids Branch

Emergency Health Service
Bureau of Health Manpower



CHAPTER PHS: 4-44

BUREAU OF HEALTH MATERIEL, EMERGENCY HEALTH SERVICE

PHS:
4-44-00 PURPOSE

This chapter describes the general objectives, organization, and functions of the Bureau of Health Materiel, Emergency Health Service (EHS). It is primarily for the use and information of personnel with emergency assignment to the Bureau and personnel having pre-emergency materiel program planning responsibilities.

PHS:
4-44-10 OBJECTIVES

The objectives of the Bureau of Health Materiel will be to provide national plans and conduct emergency programs for the utilization of the Nation's health materiel and facility resources, including the rehabilitation and construction of hospitals and related facilities, and the provision and distribution of medical and health supplies and equipment.

PHS:
4-44-20 ORGANIZATION

The responsibilities of this Bureau shall be exercised through the Office of the Bureau Chief, and the following Divisions:

Division of Resources and Requirements
Division of Claimancy and Allocation
Division of Procurement and Distribution

See Exhibit PHS: X4-44-1 for organization chart.

PHS:
4-44-30 FUNCTIONS

A. Office of the Bureau Chief - Provides general direction and supervision of Bureau activities; establishes general policies and plans necessary to achieve efficiency and effectiveness in the management of assigned emergency function; coordinates management operations with the EHS Regional Offices from the standpoint of accomplishing compliance with the Defense Civil Preparedness Agency/Department of Defense (DCPA/DOD) and the Federal Preparedness Agency/General Services Administration (FPA/GSA), legal regulatory and procedural

b. Maintains a national inventory of non-military hospital and related health facilities, by State and FPA region, through State and other reports, special surveys and damage assessment; analyzes, and plans the hospital and medical facilities survey and construction program of the Nation (including Federal, State, local government and private institutions); develops basic policy guidance, and leadership in the development of State and community programs; assists in the development of policy, regulations and procedures; maintains liaison with EHS Regional Offices, State and local governments, and industry, regarding health facility needs; prepares legislative specifications; and applies regulations and FPA, DCPA, and resource agency directives for the Bureau.

4. Architectural and Engineering Branch

a. The functions of the branch shall be performed through the Office of the Branch Chief and the following program staffs:

Architectural
Structural Engineering
Mechanical Engineering
Electrical Engineering
Construction Engineering
Specifications, Materials, and Costs

b. Furnishes technical leadership, direction, consultation and assistance on the architectural and engineering design and construction phases of the EHS program by direct implementation or assistance to EHS Regional Offices, and to States and communities when appropriate; develops criteria and standards of design and construction for remodeling and adaptation of facilities and for new construction for facilities intended as hospital and related health facilities; develops guides for use of controlled materials in hospital and related health facility construction; provides technical advice and recommendations concerning the allocation of controlled materials for the construction of hospital and related health facilities; maintains liaison with EHS Regional Offices, and Federal and non-governmental agencies, regarding construction of hospital and related health facilities; and conducts meetings with other Federal agencies, professional and industrial associations regarding the overall requirements for hospital and related health facility construction.

b. Develops EHS policies for determining priorities of controlled materiel for constructing hospital facilities, and for producer raw material requirements needed for the manufacture of health supplies and equipment; and carries out approved policies in determining the priority of applicants for construction or rehabilitation of health facilities.

3. Technical Operations Branch

a. The functions of the branch shall be performed through the Office of the Branch Chief and the following program staffs:

Claimancy Operations
Medical Industry Assistance

b. Represents EHS as claimant for controlled materials; develops policies for evaluating proposed exceptions to the policies governing Federal restrictions on the use of controlled materials for emergency construction of hospital facilities and the production of health supplies and equipment; develops policies for and promotes use of, substitute materials in order to obtain the greatest economy consistent with emergency needs; presents and justifies requests for directive action to the resource controlling agency to insure delivery of materials and equipment consistent with completion schedules of health facility construction projects; evaluates, presents, and justifies appeals from manufacturers of health supplies, building materials, and related equipment with respect to requests for controlled materials; and presents appeals for materiel and services directly to manufacturers and utility companies in cases of rapidly expanding programs or extreme and urgent local need.

4. Analysis and Reports Branch

a. The functions of the branch shall be performed through the Office of the Branch Chief and the following programs:

Program Statistics and Appraisal
Reports

b. Develops for presentation to the resource controlling agency the estimated controlled materials requirement necessary to support emergency hospital and health facility construction and production of medical survival items at an essential level; conducts studies for the appraisal of Division policies in terms of their end-effects upon the health of the civilian population and restoration of civilian medical services; and systematizes and maintains such information as is required in the operation of the Division.

Medical Depot Operations
Distribution
Requisition, Salvage, and Disposal
Quality Control
Property Management

b. Manages the Federal medical depot storage of civilian health material and the distribution of the supplies and equipment within the system; coordinates and provides technical leadership, direction, consultation, and assistance to EHS Regional Offices and States on storage problems related to proper and safe storage of medical and health related materials and equipment; interprets regulations and policies concerning storage and issue of select materials such as, drugs, vaccines, etc.; serves as liaison between EHS and other agencies on depot management and operations as it concerns civilian health services materiel; arranges for quality control, inspection, salvage, and disposal as necessary; assembles and packages functional medical assemblies for distribution in accordance with emergency plans of EHS or DCPA/DOD; conducts meetings with Government agencies and private industry representatives as necessary and appropriate in the conduct of program activities; and provides for the management of Federal real and personal property under EHS jurisdiction.

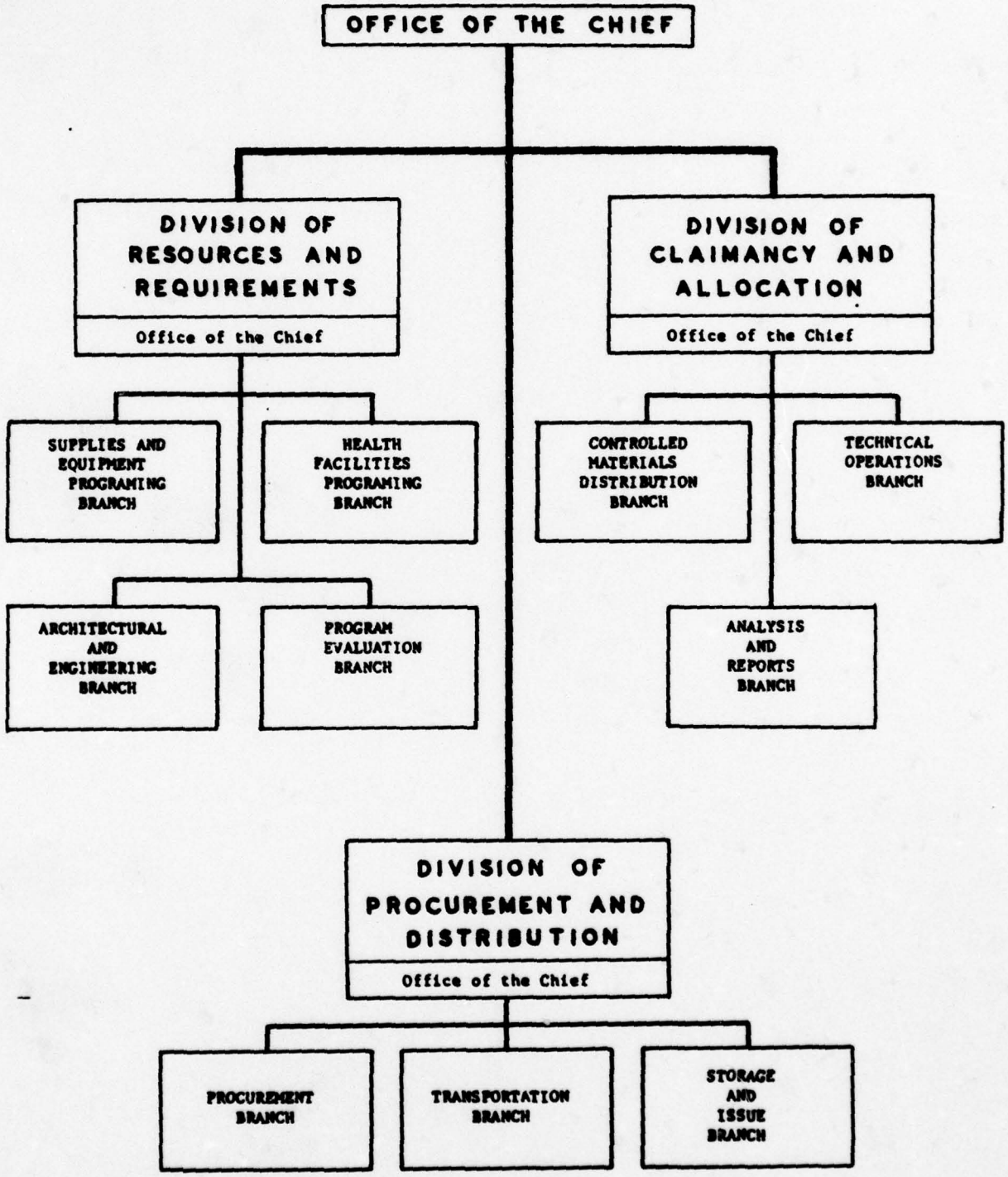
4. Transportation Branch

a. The functions of the branch shall be performed through the Office of the Branch Chief and the following program staffs:

Requirements Planning
Allocation and Priorities Control
Transportation Services

b. Serves as EHS claimant for commercial transportation service; provides centralized planning and programing of EHS responsible movements of persons and things; provides policy guidance for, and exercises technical supervision over, these movement activities through EHS Regional Offices; submits estimates for commercial transportation service for health materiel and health personnel and patients to the Department of Transportation covering requirements for transportation services in the following requirement categories: overseas air transportation, export-import shiping, domestic air transportation, and domestic surface transportation; establishes and maintains a transportation control system to insure full utilization of allocated

Emergency Health Service
Bureau of Health Materiel



CHAPTER PHS: 6-00
EMERGENCY OPERATION OF PHS FIELD FACILITIES NOT ASSIGNED A FEDERAL MISSION

PHS:
6-00-00 PURPOSE AND SCOPE

This chapter supplements portions of Chapter 6-00 and prescribes emergency actions to be taken by the Public Health Service (PHS) field facilities which will support State or local civil defense health activities in the immediate postattack period and until recalled to Federal service by higher authority.

PHS:
6-00-05 BACKGROUND

In the event of a full-scale enemy attack upon the United States, most PHS field facilities will have a vital role. Some facilities will retain a Federal mission as decentralized field units of the headquarters or regional Emergency Health Service (EHS). (See Chapter PHS: 6-10.) The primary mission of certain types of facilities will be to provide lifesaving services and support to disaster areas. The activities of installations not having emergency missions will be completely suspended and personnel assigned to more essential functions elsewhere. During the first 30 days postattack, most facilities may necessarily have to operate independently of headquarters or regional office control, guidance, and support.

PHS:
6-00-10 GENERAL POLICIES

A. Mission

1. Medical Care Facilities. All medical care facilities (e.g., hospitals, clinics, and health centers) shall be made fully available to help meet local emergency medical care needs. Facilities shall concentrate on lifesaving services and shall provide emergency services without expectation of reimbursement and without regard to normal statutory entitlement or admission policies. Medical officers in charge shall retain control of their facilities, materiel resources, and personnel.

CHAPTER PHS: 6-10

FEDERAL MISSION ASSIGNMENTS - PHS FIELD FACILITIES

PHS:
6-10-00 PURPOSE

This chapter identifies facilities which shall function as Emergency Health Service (EHS) field facilities upon reestablishment of cummunication with the Federal EHS at the DHEW Relocation Site.

PHS:
6-10-10 EHS FIELD FACILITIES

A. Center for Disease Control (CDC), Bureau of Health Operations, EHS. (See Chapter PHS: 4-42.)

B. U.S. Quarantine Stations, CDC, Bureau of Health Operations, EHS. (See Chapter PHS: 4-42.)

C. Food and Drug Administration Radiological Health Laboratories, Bureau of Health Operations, EHS. (See Chapter PHS: 4-42.)

PHS:
6-10-20 REFERENCES

A. HEW Chapter 2-10 and PHS: 2-10 for planning requirements.

B. HEW Chapter 2-80 for facility protection policy.

APPENDIX B

VARIOUS AGREEMENTS BETWEEN THE UNITED STATES PUBLIC HEALTH SERVICE AND OTHER AGENCIES OF GOVERNMENT

MATERIAL TRANSMITTED

Exhibit PHS: X1-70-1, Updating of Specifications, 1 Page.
Exhibit PHS: X1-70-2, Agreement with the Department of Labor, Pages 1-6.
Exhibit PHS: X1-70-3, Agreement with Canada, Pages 1-5.
Exhibit PHS: X1-70-4, Agreement with the Department of Commerce, Pages 1-4.
Exhibit PHS: X1-70-5, Agreement with the Veterans Administration, Pages 1-3.
Exhibit PHS: X1-70-6, Agreement with the Department of Justice, Pages 1-4.
Exhibit PHS: X1-70-7, Agreement with the Department of Agriculture, Pages 1-7.

MATERIAL SUPERSEDED

Exhibit HSM: X1-70-1 (HSM TN-72.1, 4/1/72), Pages 1-6.
Exhibit HSM: X1-70-4 (HSM TN-72.1, 4/1/72), Pages 1-5.
Exhibit HSM: X1-70-5 (HSM TN-72.1, 4/1/72), Pages 1-4.
Exhibit HSM: X1-70-6 (HSM TN-72.1, 4/1/72), Pages 1-3.
Exhibit HSM: X1-70-7 (HSM TN-73.1, 1/15/73), Pages 1-4.

MATERIAL RESCINDED

Exhibit HSM: X1-70-2 (HSM TN-72.1, 4/1/72), Pages 1-4.
Exhibit HSM: X1-70-3 (HSM TN-72.1, 4/1/72), Pages 1-5.

MANUAL MAINTENANCE

File the transmitted exhibits immediately behind the corresponding HEW chapter in the HEW Emergency Manual. Organizations having the superseded material should discard it. Post receipt of this transmittal notice in the General Series column on the Checklist of PHS Transmittal Notices.

Updating the Specification of Officials, Organizations, and Documents Referred to in Emergency Health Agreements

Under the column heading "Former Specifications" there are listed officials, organizations, and documents which are mentioned in the memoranda of understanding that are published in exhibits following this exhibit. Such officials, organizations, and documents have been retitled or superseded. The current designations are listed under the column heading "Current Specifications."

Former Specifications	Current Specifications
Executive Orders 11000 and 11001	Executive Order 11490 (as amended by Executive Order 11921)
Defense Mobilization Order 8540.1	32A CFR, Chapter 1, Part 106 July 1, 1976
Office of Emergency Planning	Federal Preparedness Agency, General Services Administration
Division of Health Mobilization, PHS	Office of Administrative Management, PHS
DHEW Regional Health Director(s)	Regional Health Administrator(s)
Division of Emergency Health Services, Health Services and Mental Health Administration, PHS	Office of Administrative Management, PHS
Office of Emergency Preparedness or successor agency	Federal Preparedness Agency, General Services Administration
Executive Order 11490	Executive Order 11490 (as amended by Executive Order 11921)
Defense Mobilization Order 8500.1A	32A CFR, Chapter 1, Part 104, July 1, 1976
Assistant Secretary for Health and Scientific Affairs	Assistant Secretary for Health
Division of Emergency Health Services Regional Program Directors	PHS designated Associate Chiefs, Regional Emergency Health Service
Office of Civil Defense	Defense Civil Preparedness Agency

MEMORANDUM OF UNDERSTANDING
BETWEEN
THE DEPARTMENT OF LABOR
AND
THE DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE
PUBLIC HEALTH SERVICE
REGARDING CIVIL DEFENSE
EMERGENCY HEALTH MANPOWER PLANNING AND MANAGEMENT

In recognition of their joint responsibilities for the mobilization and utilization of health manpower as stated in Executive Orders 11000 and 11001 and The National Plan for Emergency Preparedness, this Memorandum of Understanding is agreed to by the Deputy Under Secretary of Labor and the Surgeon General of the Public Health Service (PHS) and is published for the information and guidance of all concerned.

I. PURPOSE: The purpose of this memorandum is:

A. To distinguish between the special responsibilities of each agency with regard to civilian health manpower for emergency operations and to delineate major areas of coordination.

B. To formally establish policy and procedures in order to facilitate joint emergency planning between manpower and health officials at all levels of government.

C. To describe procedures for the maintenance of interagency working relationships.

II. DEFINITIONS: As used in this memorandum,

A. Health Manpower means manpower listed in the List of Health Manpower Occupations, in Defense Mobilization Order 8540.1 and Chapter 4, Health, of The National Plan for Emergency Preparedness. Such manpower is allocated to the Department of Health, Education, and Welfare (DHEW), by the Office of Emergency Planning for domestic civilian health services.

B. Supporting Manpower means manpower essential to health operations (e.g., hospital, sanitation, and laboratory helpers, and engineering, clerical, and food service personnel), but having skills interchangeable among health and other essential activities and, therefore, under the jurisdiction of manpower authorities.

C. Manpower Officials means officials of the Department of Labor (DOL) and its affiliated State Employment Security (SES) Offices.

D. Health Officials means the Federal, State, and local officials responsible for emergency civilian health services.

NOTE: Refer to Exhibit PHS: X1-70-1 for current specifications of officials, organizations, and documents.

B. DOL is responsible for developing national emergency plans and preparedness programs, policies and procedures for the mobilization and management of civilian manpower (other than health manpower) and for coordinating PHS health manpower plans with the over-all manpower program.

DOL therefore develops plans and issues guidance to increase the readiness of State Employment Security offices to assist the emergency health organization, including:

1. for health manpower

   a. plans to obtain and incorporate into automated processing and telecommunication systems, for emergency use, such data as will enable accelerated location of professional health manpower.

   b. instructions for the exclusive postattack referral of health manpower to health service operations and establishment of channels and procedures by which the responsible health official can effectively direct such referrals.

2. for supporting manpower

   a. plans for retention of supporting manpower employed at the time of attack by medical facilities, laboratories, or governmental health agencies.

   b. plans for the provision of additional supporting manpower according to essential activities priorities established by the manpower agency or ranking governmental official.

   c. plans for the organization of preassigned teams for emergency health service.

C. Each Department agrees:

1. to make available to the other national manpower data and estimates needed for emergency planning and operation.

2. to promote through its field representatives cooperative planning and action between health and manpower authorities at State and local levels.

DHEW Regional Offices

Region I	Connecticut, Maine, Massachusetts, New Hampshire, Rhode Island, Vermont	John F. Kennedy Federal Bldg. Boston, Mass. 02203
Region II	New Jersey, New York, Puerto Rico, Virgin Islands	Federal Building 26 Federal Plaza New York, N.Y. 10007
Region III	Delaware, Dist. of Col. Maryland, Pennsylvania, Virginia, West Virginia	3535 Market Street Philadelphia, Pa. 19101
Region IV	Alabama, Florida, Georgia, Kentucky, Mississippi, North Carolina, South Carolina, Tennessee	50 Seventh Street, N.E. Atlanta, Ga. 30323
Region V	Illinois, Indiana, Michigan, Minnesota, Ohio, Wisconsin	300 South Wacker Drive Chicago, Ill. 60606
Region VI	Arkansas, Louisiana, New Mexico, Oklahoma, Texas	1200 Main Tower Building Dallas, Texas 75202
Region VII	Iowa, Kansas, Missouri, Nebraska	601 East 12th Street Kansas City, Mo. 64106
Region VIII	Colorado, Montana, North Dakota, South Dakota, Utah, Wyoming	19th and Stout Streets Denver, Colo. 80202
Region IX	Arizona, California, Guam, Hawaii, Nevada	50 Fulton Street San Francisco, Calif. 94102
Region X	Alaska, Idaho, Oregon, Washington	1321 Second Avenue Seattle, Wash. 98101

Revised 8/26/77

Memorandum of Understanding Between Department of Health, Education and Welfare of the United States of America and the Department of National Health and Welfare of Canada Regarding The Exchange of Health Manpower in the Event of An Armed Attack on Either Country in North America

Preamble

There is generally a shortage of trained health manpower to meet normal health requirements. The increased need for such manpower in time of disaster would make this shortage critical. Because the effects of an enemy attack on either or both of our countries would not be limited by boundaries, this memorandum has been prepared to facilitate the post-attack exchange of health manpower to care for the sick and injured and to alleviate and prevent the spread of health hazards.

1. Purpose

The purpose of this memorandum is to:

A. Set out the agreed policy guidelines to be used in the development of compatible plans and procedures for the exchange of health manpower between Canada and the United States of America.

B. Encourage co-operative US/Canadian emergency health planning by the appropriate health authorities, within their respective jurisdictions, of those states, provinces and municipalities which are adjacent to one another along the International Border.

C. Assist in the removal of any serious potential impediments to cross-border assistance or emergency operations.

D. Delineate levels of responsibility and the channels of communication for the maintenance of cross-border working relationships in emergency health manpower planning and operations.

2. Scope

A. Health services are the responsibility of each state and province. Because of this, and the great variety of health disciplines, it would be unrealistic to attempt to cover all of them. The application of this memorandum will therefore be limited to those professions and occupations listed in the Annexure hereto, for which a common standard is acceptable to both countries.

B. Operational procedures in this memorandum will be effective only in a post-attack period. They will apply both to mutual support for dealing with a common survival problem and to the provision of health services, if necessary, for groups of refugees who may have crossed the International Boundary, voluntarily or by direction, to escape the effects of nuclear attack.

3. Authority

This memorandum shall constitute an administrative arrangement between the Department of Health Education and Welfare of the United States of America and the Department of National Health and Welfare of Canada, providing for co-operation and joint procedures for mutual assistance in civil emergency health planning. The arrangement is made pursuant to, and in accordance with the terms of, the "Agreement on Co-operation Between the United States and Canada on Civil Emergency Planning" concluded in Ottawa on August 8, 1967, and is subject to any superceding Agreement between the two governments. The implementation of the arrangement shall not be inconsistent with the overall manpower policy of each government in effect from time to time. Any proposed variation of the provisions of this memorandum must be within the terms of the basic agreement, and mutually agreed to by the two government departments.

4. Legislation

Federal Health officials shall encourage all states and provinces, especially those along the International Boundary, to prepare or revise necessary legislation regarding licensure to facilitate the exchange of health manpower in a post-attack period. Specifically, they shall use their best efforts to ensure that:

A. Reciprocity will be temporarily accorded licensed health practitioners who cross the International Boundary to perform emergency health services, and

NOTE: Refer to Exhibit PHS: X1-70-1 for current specifications of officials, organizations, and documents.

SCHEDULE OF HEALTH MANPOWER

United States Title	Canadian Title
Administrator, Hospital	Hospital Administrator
Anatomist	Anatomist
Audiologist	Audiologist
Audiometrist	Audiometrist
Bacteriologist—Dairy	Dairy Bacteriologist (Note 1)
Bacteriologist—Fishery	Fishery Bacteriologist
Bacterologist—Food	Food Bacteriologist (Note 1)
Bacteriologist—Medical	Medical Bacteriologist
Bacteriologist—Pharmaceutical	(No Canadian Equivalent)
Bacteriologist—Public Health	Bacteriologist
Biochemist	Biochemist
Biophysicist	Biophysicist
Chemist, Biological	Chemist, Biological
Chemist, Clinical	Chemist, Clinical
Chemist, Enzymes	Chemist, Enzymes
Chemist, Pharmaceutical	Chemist, Pharmaceutical
Chemist, Proteins	Chemist, Proteins
Chemist, Steroids	Chemist, Steroids
Chiropodist	*Chiropodist and Podiatrist (both terms used in Canada)*
Cytologist, Animal	Cytologist, Animal
Dentists	Dentists
Food and Drug Inspector (Govt. Ser.)	Food and Drug Inspector
Health Physicist	Health Physicist
Hearing Clinician	Hearing Clinician
Helminthologist	Helminthologist
Histologist	Histologist
Histopathologist	Histopathologist
Hospital Administrator	Hospital Administrator
Hygienist, Dental	Dental, Hygienist
Immunologist	Immunologist
Instructor of Blind (also Orientation Therapist for the Blind)	Instructor of Blind
Librarian, Medical-Record (Med. Ser.)	Medical Record Librarian
Medical Assistant	Medical Assistant
Medical Laboratory Assistant	Medical Laboratory Assistant
Microbiologist	Microbiologist
Midwife	Obstretrical Nurse
Nurse Aid (Med. Ser.)	Nurse Aide or Ward Aide
Nurse, Licensed, Practical	Registered or Certified Nursing Assistant
Nurse, Registered	Registered Nurse
Optometrist	Optometrist
Orderly (Med. Ser.)	Hospital Orderly
Orderly, Surgical	Hospital Orderly
Orthopedic Specialist	Orthopedic Specialist
Orthoptist	Orthoptist
Osteopathic Physician	Osteopath
Parasitologist, Medical	Parasitologist
Pharmacist	Pharmacist
Pharmacologist	Pharmacologist
Physicians and Surgeons	Physicians and Surgeons
Physiologist, Animal	Physiologist Animal
Physiologist, Medical	Medical Physiologist
Podiatrist	Chiropodist and Podiatrist (both terms used in Canada)
Prosthetist-Orthotist	Prosthetist-Orthotist
Protozoologist	Protozoologist
Psychologist, Clinical	Psychologist, Clinical
Public-Health Bacteriologist	Bacteriologist

United States Title	Canadian Title
Therapists	
Inhalation Therapist	(No Canadian Equivalent)
Occupational Therapist	Occupational Therapist
Orientation Therapist for the Blind	Instructor for the Blind
Physical Therapist	Physical Therapist
Physiotherapist	Physiotherapist
Veterinarian	Veterinarian (Note 1)
Virologist	Virologist

Canadian occupational titles for which no United States equivalents are listed:

Health Educator
Hospital Dietitian (Note 1)
Psychiatric Nurse (Note 2)
Chiropractor
Toxicologist

Note 1.

In Canada, all civilians will be subject to Emergency Manpower Regulations. All health occupations listed, except those noted, will be allocated to Emergency Health Services for direction and control. Those noted *may* be directed to emergency health employment depending on the priorities at the time, and the possible need for them in other occupations (e.g. Emergency Welfare Services).

Note 2.

In Canada, one who has completed a course of 2 or 3 years in a mental hospital and is prepared to nurse psychiatric patients.

MEMORANDUM OF UNDERSTANDING
BETWEEN
THE PUBLIC HEALTH SERVICE
OF THE
DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE
AND THE
BUREAU OF DOMESTIC COMMERCE
OF THE
DEPARTMENT OF COMMERCE

I. PURPOSE

This memorandum defines the working relationships between the Public Health Service (PHS), Department of Health, Education, and Welfare, and the Bureau of Domestic Commerce (BDC), Department of Commerce, with respect to the emergency domestic distribution of health end-items. The agreements herein are limited to plans and procedures covering the distribution of primary inventories of health end-items in the survival period immediately following attack upon the United States. Subsequently, the PHS will allocate such end-items made available by the Office of Emergency Preparedness or successor agency to all assigned sectors of the domestic economy.

II. AUTHORITY

Executive Order 11490, as amended, assigns emergency preparedness functions to Federal departments and agencies. The Secretary of Commerce develops preparedness programs covering the production and distribution of all materials except those delegated to other Federal departments and agencies. The responsibility for maintaining such preparedness programs in the industrial production sector has been delegated to the Director, Bureau of Domestic Commerce by the Secretary of Commerce in Department Organization Order 40-1A.

The Public Health Service, by delegation from the Secretary of Health, Education, and Welfare, is responsible for directing the domestic distribution of health end-items following an attack upon the United States in accordance with policy guidance provided by the Director of the Office of Emergency Preparedness or successor agency.

NOTE: Refer to Exhibit PHS: X1-70-1 for current specifications of officials, organizations, and documents.

1. Adjustment of patterns of distribution of primary inventories of health end-items to meet shortages reported by State and local governments.

2. Estimates of continuing requirements for health end-items.

3. Estimates of the continuing requirements of essential health facilities for maintenance, repair and operating supplies (MRO) produced and distributed under BDC jurisdiction.

4. Estimates of major repair and construction requirements for essential health facilities.

B. BDC, recognizing that PHS has full responsibility for and authority over domestic distribution of health end-items following armed attack on the U. S., agrees to:

1. Provide for the distribution of primary inventories of health end-items in accordance with distribution patterns developed by PHS.

2. Provide estimates to PHS of the quantities of health end-items and MRO supplies which will be available to essential health facilities.

3. Authorize essential health facilities to place DO-F1 rated orders upon their normal primary suppliers of health end-items.

4. Provide essential health facilities with the authority to place DO-F1 rated orders upon primary suppliers of industrial products required as MRO and capital equipment.

5. Direct new production of health end-items, MRO and capital equipment in such a manner as to meet, to the extent feasible, the continuing requirements of essential health facilities.

6. Include in BDC Emergency Regulation No. 1 the authorizations to essential health facilities

MEMORANDUM OF UNDERSTANDING BETWEEN THE VETERANS ADMINISTRATION AND THE DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE, REGARDING PARTICIPATION IN EMERGENCY HEALTH SERVICE PLANNING AND OPERATIONS

In recognition of the substantial emergency health responsibilities and resources of the Veterans Administration (VA), and in accordance with Executive Order No. 11490, and the National Plan for Emergency Preparedness, this Memorandum of Understanding has been agreed to by the VA, Department of Medicine and Surgery (DM&S), and the Department of Health, Education, and Welfare (DHEW), Public Health Service (PHS), and is published for the guidance and information of all concerned.

I. PURPOSE. The purpose of this memorandum is:

A. To ensure the maximum emergency utilization of VA health resources following an attack upon the United States.

B. To facilitate the early development of joint emergency health operating plans.

C. To describe the medical and health program planning areas in which the VA and DHEW will assist each other.

D. To describe procedures for the maintenance of interagency working relationships in the health and medical fields.

II. AUTHORITY. In accordance with Executive Order No. 11490, "The Administrator of Veterans Affairs shall develop policies, plans, and procedures for the performance of emergency functions with respect to the continuation or restoration of authorized programs of the Veterans Administration under all conditions of national emergency, including attack upon the United States. These include: (1) The emergency conduct of inpatient and outpatient care and treatment in Veterans Administration medical facilities and participation with the Departments of Defense and Health, Education, and Welfare as provided for in interagency agreements."

III. EMERGENCY OPERATIONS. In the initiation and conduct of emergency operations, the following general policies will prevail:

A. Headquarters. The VA Central Office staff shall have a substantial role in the Federal Emergency Health Service (EHS). A VA DM&S official shall serve as Associate Chief, EHS. Certain predesignated VA employees will relocate at the DHEW Relocation Site as part of the EHS Cadre; others will report there for duty at D plus 14 or later. The specific emergency responsibility of each assignee

NOTE: Refer to Exhibit PHS: X1-70-1 for current specifications of officials, organizations, and documents.

to DM&S will be sent to the Chief Medical Director with copies for the VA Defense Coordinator. Staff units and officials of DM&S and PHS shall meet or confer informally to discuss matters of joint concern.

At the regional and field level, joint planning shall be conducted by contact between VA-designated Associate Chiefs, Regional EHS, and the DEHS Regional Program Directors. Formal arrangements shall be approved by the DHEW Regional Health Directors and the Associate Chiefs, REHS. Regional policy precedent matters shall be referred to headquarters for interagency action and resolution.

B. Joint Issuance. Each agency shall routinely provide to the other all pertinent emergency issuances. Proposed issuances directly involving the other agency shall be submitted to that agency for review and clearance prior to publication.

C. Essential Records and References. Designated VA relocatees to EHS shall select record and reference materials essential to the conduct of their assigned emergency responsibilities. These materials shall be filed at the DHEW Relocation Site in conformance with DHEW policy and procedures.

D. Security. All designated DM&S headquarters relocatees, both principal and alternate, shall have security clearance. D-minus cadre relocatees shall have clearance based upon full field investigation.

E. Exercises and Tests. Designated VA relocatees shall participate in EHS headquarters and regional exercises and tests.

FOR THE VETERANS ADMINISTRATION

Chief Medical Director

J. C. Larson

Defense Coordinator

FOR THE DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE

Assistant Secretary for Health and Scientific Affairs

Defense Coordinator

March 14, 1972
Date

NOTE: This agreement supersedes the Memorandum of Understanding dated July 22, 1966.

MEMORANDUM OF UNDERSTANDING
BETWEEN
THE PUBLIC HEALTH SERVICE
OF THE
DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE
AND THE
BUREAU OF NARCOTICS AND DANGEROUS DRUGS
OF THE
DEPARTMENT OF JUSTICE

I. PURPOSE

This memorandum defines the working relationships between the Bureau of Narcotics and Dangerous Drugs (BNDD), Department of Justice, and the Public Health Service (PHS), Department of Health, Education, and Welfare, with respect to the domestic distribution of narcotics and other controlled substances in a postattack situation. The agreements herein are limited to plans and procedures covering the distribution of inventories of controlled substances in the survival period assuming an attack upon the United States. During the recovery period, the PHS will allocate such quantities of controlled substances as are made available by the Office of Defense Resources (ODR). The control procedures and distribution methods of the BNDD shall be utilized.

II. AUTHORITY

A. Public Law 91-513 - Comprehensive Drug Abuse Prevention and Control Act of 1970.

B. Executive Order 11490 - Assigning Emergency Preparedness Functions to Federal Departments and Agencies, 1969. The Attorney General, Department of Justice, develops preparedness programs covering the distribution of all controlled substances as listed in Title 21, Part 308, of the Code of Federal Regulations. The duties and functions of the Attorney General under Public Law 91-513 have been delegated to the Director, BNDD. The responsibility for maintaining such preparedness programs has been delegated to the Assistant Director for Administration, Emergency Preparedness Planning Coordinator (EPPC). The Public Health Service, by delegation from the Secretary of Health, Education, and Welfare, is responsible

NOTE: Refer to Exhibit PHS: X1-70-1 for current specifications of officials, organizations, and documents.

IV. EMERGENCY PREPAREDNESS

In the event of disruption of communications among the national, regional, and field office levels of BNDD and the national and regional levels of PHS, the provisions of this memorandum will be carried out at the highest regional or State levels of the two agencies which are in communication with one another until such time as effective communications with national headquarters have been reestablished.

V. ASSIGNED FUNCTIONS

A. PHS agrees to provide BNDD with direction and/or information regarding, but not limited to:

1. Adjustment of patterns of distribution of primary inventories of controlled drug end-items to meet shortages reported by State and local governments.

2. Estimates of continuing requirements for controlled substances.

3. Procedures to meet the needs for controlled substances in the immediate postattack survival period.

4. Procedures for controls at the retail levels, during such time as rationing (Economic Stabilization) procedures are in effect.

B. BNDD, recognizing the PHS has full responsibility for and authority over civilian health and medical care following attack on the United States, agrees to:

1. Authorize the distribution of primary inventories of controlled substances under its jurisdiction in accordance with distribution patterns developed by PHS.

2. Authorize designated Civil Defense Narcotic Procurement Officers to place orders upon their normal primary suppliers of controlled substances.

MEMORANDUM OF UNDERSTANDING ON GENERAL WAR FOOD INSPECTION BETWEEN U.S. DEPARTMENT OF AGRICULTURE AND THE DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE

In recognition of the joint responsibilities of the Department of Health, Education, and Welfare (DHEW) and the U.S. Department of Agriculture (USDA) for the purity and safety in the manufacture, production, processing and distribution of food under Executive Order 11490, this Memorandum of Understanding concerning emergency preparedness and postattack operations relative to food purity and safety inspection is agreed to and is published for guidance of all concerned.

I. PURPOSE.

The purpose of this memorandum is:

A. To define and describe procedures for the maintenance of interagency postattack working relationships relative to food inspection for purity and safety in the event of general war.

(1) To delineate the responsibilities of each agency with regard to inspectional procedures for emergency operations.

(2) To establish procedures for coordination of DHEW and USDA food inspection in wartime.

B. To establish policy and procedures to facilitate joint emergency planning for emergency utilization of inspection capabilities.

II. POLICY.

It is the intent of USDA and DHEW to assure the public as safe a food supply as is possible under postattack conditions. The relaxation of FDA inspection standards which would be necessary following the beginning of a general war will be limited to the first two weeks following the beginning of a general war unless specifically extended by the Commissioner of Food and Drugs, DHEW, or such other Federal officials as may be designated to act. The emergency period inspection guidance provided herein, shall be regarded as minimum, and normal inspection and standards shall be used wherever and whenever possible except when normal standards would reduce the amount of food available to less than needed quantities.

NOTE: Refer to Exhibit PHS: X1-70-1 for current specifications of officials, organizations, and documents.

C. Food Inspection. Food Inspection refers to the inspection of commodities and facilities of manufacturers, and processing, handling, storing, or distribution of food in warehouses and of wholesale distributors.

(1) Emergency purity and safety inspection shall be limited to visual inspection for spoilage, disease, filth, and other dangerous contamination. During the initial post-attack period, no instrumentation or laboratory analysis will be included in such an inspection unless the inspector in his professional judgment and/or based on other information, believes the food may be contaminated with injurious substances which require detection and evaluation by instrumented procedures or laboratory analysis.

D. Inspectors. Include USDA personnel who have been oriented by FDA guidelines as emergency food inspectors to carry out emergency functions.

E. Single Inspection Concept. The Single Inspection Concept, as applied to inspection for the purity and safety of food, means an inspection performed by FDA, USDA and by other designated and qualified Federal, State or local agency personnel.

F. General War. For purposes of this agreement, general war includes a nuclear attack upon the United States. The use of biological and chemical agents is possible. While strategic warning is a possibility, the attack will create unprecedented and exceedingly difficult problems in the immediate postattack period.

G. Chemical Warfare Agents. These agents are chemical substances which by their own action produce a physiological reaction in man, animals, or crops.

V. DELEGATION OF DHEW/FDA EMERGENCY RESPONSIBILITIES TO USDA.

To facilitate the inspection of food for safety and purity in the postattack period, the DHEW/FDA authorizes the following:

A. USDA Food Inspectors and Food Graders or USDA designated Food Inspectors and Food Graders may approve for DHEW, fruits, vegetables, dairy products, meat and poultry, eggs and products thereof, and grain which they inspect in the immediate postattack period, as meeting DHEW emergency standards for safety and purity.

B. To attain the optimum cooperative utilization of available USDA designated personnel with inspection capabilities for inspection of food in the initial postattack

to the food products. Unless diseases are observed or are reported to the inspector as known in his area, food shall not be withheld from use for fear of biological warfare contamination.

(3) Chemical Warfare. Possibility of contamination of food by chemical warfare agents shall not be a basis for condemnation of food or withholding of otherwise safe food, unless the Office of Civil Defense or other responsible agency reports that chemical warfare agents have been detected in the area.

B. Interagency Coordination. Staff units and officials of USDA and DHEW/FDA shall confer on matters of joint concern and furnish plans for the efficient utilization of inspection services for postattack operation.

(1) This agreement assures that:

(a) Bulk foods in damaged facilities or foods in packages which have been broken will be inspected for purity and safety before use, and the inspector shall determine the appropriate disposition.

(b) Damaged food manufacturing establishments and storage and handling facilities may continue to operate following any needed decontamination and minimum essential repairs.

(c) Resumption of manufacturing or processing operations is permitted as soon as equipment is determined safe for use.

(2) During the emergency, USDA personnel designated as emergency inspectors may be shifted from their regular stations into an affected area elsewhere for such periods of time as the emergency requires at the request of DHEW/FDA with concurrence of USDA.

C. Joint Issuances. USDA and DHEW/FDA shall routinely provide all pertinent announcements and/or directives to each other relative to food inspection procedures and policies. Proposed issuances directly involving assigned functions of the other agency shall be submitted to that agency for concurrence prior to issuance.

VII. EMERGENCY OPERATIONS.

In initiating and conducting emergency operations, the following general policies will be followed:

FOR THE U.S. DEPARTMENT
OF AGRICULTURE

Clifford M. Hardin
Secretary

Oct. 1, 1971
Date

FOR THE DEPARTMENT OF HEALTH,
EDUCATION, AND WELFARE

Elliot L. Richardson
Secretary

SEP 24 1971
Date

Charles C. Edwards
Commissioner, FDA

5/25/71
Date

Roger O. Egeberg
Assistant Secretary for Health
and Scientific Affairs

MAY 26 1971
Date

APPENDIX C

THE NATIONAL HEALTH PLANNING AND RESOURCES DEVELOPMENT ACT OF 1974

Public Law 93-641
93rd Congress, S. 2994
January 4, 1975

An Act

88 STAT. 2225

To amend the Public Health Service Act to assure the development of a national health policy and of effective State and area health planning and resources development programs, and for other purposes.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SHORT TITLE; TABLE OF CONTENTS

National Health Planning and Resources Development Act of 1974. 42 USC 300k note.

SECTION 1. This Act may be cited as the "National Health Planning and Resources Development Act of 1974".

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FINDINGS AND PURPOSE

42 USC 300k.

SEC. 2. (a) The Congress makes the following findings:

(1) The achievement of equal access to quality health care at a reasonable cost is a priority of the Federal Government.

(2) The massive infusion of Federal funds into the existing health care system has contributed to inflationary increases in the cost of health care and failed to produce an adequate supply or distribution of health resources, and consequently has not made possible equal access for everyone to such resources.

(3) The many and increasing responses to these problems by the public sector (Federal, State, and local) and the private sector have not resulted in a comprehensive, rational approach to the present—

(A) lack of uniformly effective methods of delivering health care;

(B) maldistribution of health care facilities and manpower; and

(C) increasing cost of health care.

(4) Increases in the cost of health care, particularly of hospital stays, have been uncontrollable and inflationary, and there are presently inadequate incentives for the use of appropriate alternative levels of health care, and for the substitution of ambulatory and intermediate care for inpatient hospital care.

(5) Since the health care provider is one of the most important participants in any health care delivery system, health policy must address the legitimate needs and concerns of the provider if it is to achieve meaningful results; and, thus, it is imperative

that the provider be encouraged to play an active role in developing health policy at all levels.

(6) Large segments of the public are lacking in basic knowledge regarding proper personal health care and methods for effective use of available health services.

(b) In recognition of the magnitude of the problems described in subsection (a) and the urgency placed on their solution, it is the purpose of this Act to facilitate the development of recommendations for a national health planning policy, to augment areawide and State planning for health services, manpower, and facilities, and to authorize financial assistance for the development of resources to further that policy.

REVISION OF HEALTH PLANNING PROGRAMS UNDER THE PUBLIC HEALTH SERVICE ACT

SEC. 2. The Public Health Service Act is amended by adding at the end the following new title: 42 USC 201 note.

"TITLE XV—NATIONAL HEALTH PLANNING AND DEVELOPMENT

"PART A—NATIONAL GUIDELINES FOR HEALTH PLANNING

"NATIONAL GUIDELINES FOR HEALTH PLANNING

"SEC. 1501. (a) The Secretary shall, within eighteen months after the date of the enactment of this title, by regulation issue guidelines concerning national health planning policy and shall, as he deems appropriate, by regulation revise such guidelines. Regulations under this subsection shall be promulgated in accordance with section 553 of title 5, United States Code. 42 USC 300k-1.

"(b) The Secretary shall include in the guidelines issued under subsection (a) the following:

"(1) Standards respecting the appropriate supply, distribution, and organization of health resources.

"(2) A statement of national health planning goals developed after consideration of the priorities, set forth in section 1502, which goals, to the maximum extent practicable, shall be expressed in quantitative terms.

"(c) In issuing guidelines under subsection (a) the Secretary shall consult with and solicit recommendations and comments from the health systems agencies designated under part B, the State health planning and development agencies designated under part C, the Statewide Health Coordinating Councils established under part C, associations and specialty societies representing medical and other health care providers, and the National Council on Health Planning and Development established by section 1503. Post, p. 2229. Post, p. 2242.

"NATIONAL HEALTH PRIORITIES

"SEC. 1502. The Congress finds that the following deserve priority consideration in the formulation of national health planning goals and in the development and operation of Federal, State, and area health planning and resources development programs: 42 USC 300k-2.

"(1) The provision of primary care services for medically underserved populations, especially those which are located in rural or economically depressed areas.

"(2) The development of multi-institutional systems for coordination or consolidation of institutional health services (including obstetric, pediatric, emergency medical, intensive and coronary care, and radiation therapy services).

"(3) The development of medical group practices (especially those whose services are appropriately coordinated or integrated with institutional health services), health maintenance organizations, and other organized systems for the provision of health care.

"(4) The training and increased utilization of physician assistants, especially nurse clinicians.

"(5) The development of multi-institutional arrangements for the sharing of support services necessary to all health service institutions.

"(6) The promotion of activities to achieve needed improvements in the quality of health services, including needs identified by the review activities of Professional Standards Review Organizations under part B of title XI of the Social Security Act. 42 USC 1320c.

"(7) The development by health service institutions of the capacity to provide various levels of care (including intensive care, acute general care, and extended care) on a geographically integrated basis.

"(8) The promotion of activities for the prevention of disease, including studies of nutritional and environmental factors affecting health and the provision of preventive health care services.

"(9) The adoption of uniform cost accounting, simplified reimbursement, and utilization reporting systems and improved management procedures for health service institutions.

"(10) The development of effective methods of educating the general public concerning proper personal (including preventive) health care and methods for effective use of available health services.

"NATIONAL COUNCIL ON HEALTH PLANNING AND DEVELOPMENT

"SEC. 1503. (a) There is established in the Department of Health, Education, and Welfare an advisory council to be known as the National Council on Health Planning and Development (hereinafter in this section referred to as the 'Council'). The Council shall advise, consult with, and make recommendations to, the Secretary with respect to (1) the development of national guidelines under section 1501, (2) the implementation and administration of this title and title XVI, and (3) an evaluation of the implications of new medical technology for the organization, delivery, and equitable distribution of health care services. Establishment. 42 USC 300k-3.

"(b)(1) The Council shall be composed of fifteen members. The Chief Medical Director of the Veterans' Administration, the Assistant Secretary for Health and Environment of the Department of Defense, and the Assistant Secretary for Health of the Department of Health, Education, and Welfare shall be nonvoting ex officio members of the Council. The remaining members shall be appointed by the Secretary and shall be persons who, as a result of their training, experience, or attainments, are exceptionally well qualified to assist in carrying out the functions of the Council. Of the voting members, not less than five shall be persons who are not providers of health services, not more than three shall be officers or employees of the Federal Government, not less than three shall be members of governing bodies of Membership.

health systems agencies designated under part B, and not less than three shall be members of Statewide Health Coordinating Councils under section 1524. The two major political parties shall have equal representation among the voting members on the Council.

Post, p. 2247.

Terms of office.

"(2) The term of office of voting members of the Council shall be six years, except that—

"(A) of the members first appointed to the Council, four shall be appointed for terms of two years and four shall be appointed for terms of four years, as designated by the Secretary at the time of appointment; and

"(B) any member appointed to fill a vacancy occurring prior to the expiration of the term for which his predecessor was appointed shall be appointed only for the remainder of such term.

A member may serve after the expiration of his term until his successor has taken office.

"(3) The chairman of the Council shall be selected by the voting members from among their number. The term of office of the chairman of the Council shall be the lesser of three years or the period remaining in his term of office as a member of the Council.

Compensation.

"(c)(1) Except as provided in paragraph (2), the members of the Council shall each be entitled to receive the daily equivalent of the annual rate of basic pay in effect for grade GS-18 of the General Schedule for each day (including traveltime) during which they are engaged in the actual performance of duties vested in the Council.

5 USC 5332 and note.

"(2) Members of the Council who are full-time officers or employees of the United States shall receive no additional pay on account of their service on the Council.

Travel expenses.

"(3) While away from their homes or regular places of business in the performance of services for the Council, members of the Council shall be allowed travel expenses, including per diem in lieu of subsistence, in the same manner as persons employed intermittently in the Government service are allowed expenses under section 5703(b) of title 5, United States Code.

Experts and consultants.

"(d) The Council may appoint, fix the pay of, and prescribe the functions of such personnel as are necessary to carry out its functions. In addition, the Council may procure the services of experts and consultants as authorized by section 3109 of title 5, United States Code, but without regard to the last sentence of such section.

5 USC app. 1.

"(e) The provisions of section 14(a) of the Federal Advisory Committee Act shall not apply with respect to the Council.

"Part B—Health Systems Agencies

"Health service areas

Establishment. 42 USC 3001.

"Sec. 1511. (a) There shall be established, in accordance with this section, health service areas throughout the United States with respect to which health systems agencies shall be designated under section 1515. Each health service area shall meet the following requirements:

Requirements.

"(1) The area shall be a geographic region appropriate for the effective planning and development of health services, determined on the basis of factors including population and the availability of resources to provide all necessary health services for residents of the area.

"(2) To the extent practicable, the area shall include at least one center for the provision of highly specialized health services.

"(3) The area, upon its establishment, shall have a population of not less than five hundred thousand or more than three million; except that—

"(A) the population of an area may be more than three million if the area includes a standard metropolitan statistical area (as determined by the Office of Management and Budget) with a population of more than three million, and

"(B) the population of an area may—

"(i) be less than five hundred thousand if the area comprises an entire State which has a population of less than five hundred thousand, or

"(ii) be less than—

"(I) five hundred thousand (but not less than two hundred thousand) in unusual circumstances (as determined by the Secretary), or

"(II) two hundred thousand in highly unusual circumstances (as determined by the Secretary).

if the Governor of each State in which the area is located determines, with the approval of the Secretary, that the area meets the other requirements of this subsection.

42 USC 1320c-1.

"(4) To the maximum extent feasible, the boundaries of the area shall be appropriately coordinated with the boundaries of areas designated under section 1152 of the Social Security Act for Professional Standards Review Organizations; existing regional planning areas, and State planning and administrative areas. The boundaries of a health service area shall be established so that, in the planning and development of health services to be offered within the health service area, any economic or geographic barrier to the receipt of such services in nonmetropolitan areas is taken into account. The boundaries of health service areas shall be established so as to recognize the differences in health planning and health services development needs between nonmetropolitan and metropolitan areas. Each standard metropolitan statistical area shall be entirely within the boundaries of one health service area, except that if the Governor of each State in which a standard metropolitan statistical area is located determines, with the approval of the Secretary, that in order to meet the other requirements of this subsection a health service area should contain only part of the standard metropolitan statistical area, then such statistical area shall not be required to be entirely within the boundaries of such health service area.

Notice to Governors.

"(b)(1) Within thirty days following the date of the enactment of this title, the Secretary shall simultaneously give to the Governor of each State written notice of the initiation of proceedings to establish health service areas throughout the United States. Each notice shall contain the following:

"(A) A statement of the requirement (in subsection (a)) of the establishment of health service areas throughout the United States.

"(B) A statement of the criteria prescribed by subsection (a) for health service areas and the procedures prescribed by this subsection for the designation of health service area boundaries.

"(C) A request that the Governor receiving the notice (i) designate the boundaries of health service areas within his State, and, where appropriate and in cooperation with the Governors of adjoining States, designate the boundaries within his State of health service areas located both in his State and in adjoining States, and (ii) submit (in such form and manner as the Secretary shall specify) to the Secretary, within one hundred and twenty

days of the date of enactment of this title, such boundary designations together with comments, submitted by the entities referred to in paragraph (2), with respect to such designations.

At the time such notice is given under this paragraph to each Governor, the Secretary shall publish as a notice in the Federal Register a statement of the giving of his notice to the Governor and the criteria and procedures contained in such notice.

Publication in Federal Register.

"(2) Each State's Governor shall in the development of boundaries for health service areas consult with and solicit the views of the chief executive officer or agency of the political subdivisions within the State, the State agency which administers or supervises the administration of the State's health planning functions under a State plan approved under section 314(a), each entity within the State which has developed a comprehensive regional, metropolitan, or other local area plan or plans referred to in section 314(b), and each regional medical program established in the State under the title IX.

42 USC 246.

"(3)(A) Within two hundred and ten days after the date of enactment of this title, the Secretary shall publish as a notice in the Federal Register the health service area boundary designations. The boundaries for health service areas submitted by the Governors shall, except as otherwise provided in subparagraph (B), constitute upon their publication in the Federal Register the boundaries for such health service areas.

42 USC 299.

Publication in Federal Register.

"(B)(i) If the Secretary determines that a boundary submitted to him for a health service area does not meet the requirements of subsection (a), he shall, after consultation with the Governor who submitted such boundary, make such revision in the boundary for such area (and as necessary, in the boundaries for adjoining health service areas) as may be necessary to meet such requirements and publish such revised boundary (or boundaries); and the revised boundary (or boundaries) shall upon publication in the Federal Register constitute the boundary (or boundaries) for such health service area (or areas). The Secretary shall notify the Governor of each State in which is located a health service area whose boundary is revised under this clause of the boundary revision and the reasons for such revision.

Boundary revision; publication in Federal Register.

"(ii) In the case of areas of the United States not included within the boundaries for health service areas submitted to the Secretary as requested under the notice under paragraph (1), the Secretary shall establish and publish in the Federal Register health service area boundaries which include such areas. The Secretary shall notify the Governor of each State in which is located a health service area the boundary for which is established under this clause of the boundaries established. In carrying out the requirement of this clause, the Secretary may make such revisions in boundaries submitted under subparagraph (A) as he determines are necessary to meet the requirement of subsection (a) for the establishment of health service areas throughout the United States.

Other health service areas; publication in Federal Register.

"(4) The Secretary shall review on a continuing basis and at the request of any Governor or designated health systems agency the appropriateness of the boundaries of the health service areas established under paragraph (3) and, if he determines that a boundary for a health service area no longer meets the requirements of subsection (a), he may revise the boundaries in accordance with the procedures prescribed by paragraph (3)(B)(ii) for the establishment of boundaries of health service areas which include areas not included in boundaries submitted by the Governors. If the Secretary acts on his own initiative to revise the boundaries of any health service area, he shall consult with the Governor of the appropriate State or States, the entities referred to in paragraph (2), the appropriate health systems agency or agencies designated under part B and the appropriate Statewide Health Coordinating Council established under part C. A request for boundary revision shall be made only after consultation with the Governor of the appropriate State or States, the entities referred to in paragraph (2), the appropriate designated health systems agencies, and the appropriate established Statewide Health Coordinating Council and shall include the comments concerning the revision made by the entities consulted in requesting the revision.

Review.

Ante, p. 2229.

Post, p. 2242.

"(5) Within one year after the date of the enactment of this title the Secretary shall complete the procedures for the initial establishment of the boundaries of health service areas which (except as provided in section 1535) include the geographic area of all the States.

Post, p. 2256.

"(c) Notwithstanding any other requirement of this section, an area—

"(1) for which has been developed a comprehensive regional, metropolitan area, or other local area plan referred to in section 314(b), and

42 USC 246.

"(2) which otherwise meets the requirements of subsection (a), shall be designated by the Secretary as a health service area unless the Governor of any State in which such area is located, upon a finding that another area is a more appropriate region for the effective planning and development of health resources, waives such requirement.

"HEALTH SYSTEMS AGENCIES

"SEC. 1512. (a) DEFINITION.—For purposes of this title, the term 'health systems agency' means an entity which is organized and operated in the manner described in subsection (b) and which is capable, as determined by the Secretary, of performing each of the functions described in section 1513. The Secretary shall by regulation establish standards and criteria for the requirements of subsection (b) and section 1513.

42 USC 300l-1.

Standards and criteria.

"(b)(1) LEGAL STRUCTURE.—A health systems agency for a health service area shall be—

"(A) a nonprofit private corporation (or similar legal mechanism such as a public benefit corporation) which is incorporated in the State in which the largest part of the population of the health service area resides, which is not a subsidiary of, or otherwise controlled by, any other private or public corporation or other legal entity, and which only engages in health planning and development functions;

"(B) a public regional planning body if (i) it has a governing board composed of a majority of elected officials of units of general local government or it is authorized by State law (in effect before the date of enactment of this subsection) to carry out health planning and review functions such as those described in section 1513, and (ii) its planning area is identical to the health service area; or

"(C) a single unit of general local government if the area of the jurisdiction of that unit is identical to the health service area.

A health systems agency may not be an educational institution or operate such an institution.

"(2) STAFF.—

"(A) EXPERTISE.—A health systems agency shall have a staff which provides the agency with expertise in at least the following:

(i) Administration, (ii) the gathering and analysis of data, (iii) health planning, and (iv) development and use of health resources. The functions of planning and of development of health resources shall be conducted by staffs with skills appropriate to each function.

"(B) SIZE AND EMPLOYMENT.—The size of the professional staff of any health systems agency shall be not less than five, except that if the quotient of the population (rounded to the next highest one hundred thousand) of the health service area which the agency serves divided by one hundred thousand is greater than five, the minimum size of the professional staff shall be the lesser of (i) such quotient, or (ii) twenty-five. The members of the staff shall be selected, paid, promoted, and discharged in accordance with such system as the agency may establish, except that the rate of pay for any position shall not be less than the rate of pay prevailing in the health service area for similar positions in other public or private health service entities. If necessary for the performance of its functions, a health systems agency may employ consultants and may contract with individuals and entities for the provision of services. Compensation for consultants and for contracted services shall be established in accordance with standards established by regulation by the Secretary.

Consultants and contracted services.

"(3) GOVERNING BODY.—

"(A) IN GENERAL.—A health systems agency which is a public regional planning body or unit of general local government shall, in addition to any other governing body, have a governing body for health planning, which is established in accordance with subparagraph (C), which shall have the responsibilities prescribed by subparagraph (B), and which has exclusive authority to perform for the agency the functions described in section 1513. Any other health systems agency shall have a governing body composed, in accordance with subparagraph (C), of not less than ten members and of not more than thirty members, except that the number of members may exceed thirty if the governing body has established another unit (referred to in this paragraph as an 'executive committee') composed, in accordance with subparagraph (C), of not more than twenty-five members of the governing body and has delegated to that unit the authority to take such action (other than the establishment and revision of the plans referred to in subparagraph (B)(ii)) as the governing body is authorized to take.

"(B) RESPONSIBILITIES.—The governing body—

"(i) shall be responsible for the internal affairs of the health systems agency, including matters relating to the staff of the agency, the agency's budget, and procedures and criteria (developed and published pursuant to section 1532) applicable to its functions under subsections (e), (f), and (g) of section 1513;

Post, p. 2251.

"(ii) shall be responsible for the establishment of the health systems plan and annual implementation plan required by section 1513(b);

"(iii) shall be responsible for the approval of grants and contracts made and entered into under section 1513(e)(3);

Grants and contracts, approval.

"(iv) shall be responsible for the approval of all actions taken pursuant to subsections (e), (f), (g), and (h), of section 1513;

"(v) shall (I) issue an annual report concerning the activities of the agency, (II) include in that report the health

Report.

systems plan and annual implementation plan developed by the agency, and a listing of the agency's income, expenditures, assets, and liabilities, and (III) make the report readily available to the residents of the health service area and the various communications media serving such area;

"(vi) shall reimburse its members for their reasonable costs incurred in attending meetings of the governing body;

"(vii) shall meet at least once in each calendar quarter of a year and shall meet at least two additional times in a year unless its executive committee meets at least twice in that year; and

"(viii) shall (I) conduct its business meetings in public, (II) give adequate notice to the public of such meetings, and (III) make its records and data available, upon request, to the public.

The governing body (and executive committee (if any)) of a health systems agency shall act only by vote of a majority of its members present and voting at a meeting called upon adequate notice to all of its members and at which a quorum is in attendance. A quorum for a governing body and executive committee shall be not less than one-half of its members.

"(C) COMPOSITION.—The membership of the governing body and the executive committee (if any) of an agency shall meet the following requirements:

"(i) A majority (but not more than 60 per centum of the members) shall be residents of the health service area served by the entity who are consumers of health care and who are not (nor within the twelve months preceding appointment been) providers of health care and who are broadly representative of the social, economic, linguistic and racial populations, geographic areas of the health service area, and major purchasers of health care.

"(ii) The remainder of the members shall be residents of the health service area served by the agency who are providers of health care and who represent (I) physicians (particularly practicing physicians), dentists, nurses, and other health professionals, (II) health care institutions (particularly hospitals, long-term care facilities, and health maintenance organizations), (III) health care insurers, (IV) health professional schools, and (V) the allied health professions. Not less than one-third of the providers of health care who are members of the governing body or executive committee of a health systems agency shall be direct providers of health care (as described in section 1531(3)).

"(iii) The membership shall—

"(I) include (either through consumer or provider members) public elected officials and other representatives of governmental authorities in the agency's health service area and representatives of public and private agencies in the area concerned with health,

"(II) include a percentage of individuals who reside in nonmetropolitan areas within the health service area which percentage is equal to the percentage of residents of the area who reside in nonmetropolitan areas, and

"(III) if the health systems agency serves an area in which there is located one or more hospitals or other health care facilities of the Veterans' Administration, include, as an ex officio member, an individual whom the Chief Medical Director of the Veterans' Administration

shall have designated for such purpose, and if the agency serves an area in which there is located one or more qualified health maintenance organizations (within the meaning of section 1310), include at least one member who is representative of such organizations. 42 USC 300e-9.

"(iv) If, in the exercise of its functions, a governing body or executive committee appoints a subcommittee of its members or an advisory group, it shall, to the extent practicable, make its appointments to any such subcommittee or group in such a manner as to provide the representation on such subcommittee or group described in this subparagraph.

"(4) INDIVIDUAL LIABILITY.—No individual who, as a member or employee of a health systems agency, shall, by reason of his performance of any duty, function, or activity required of, or authorized to be undertaken by, the agency under this title, be liable for the payment of damages under any law of the United States or any State (or political subdivision thereof) if he has acted within the scope of such duty, function, or activity, has exercised due care, and has acted, with respect to that performance, without malice toward any person affected by it.

"(5) PRIVATE CONTRIBUTIONS.—No health systems agency may accept any funds or contributions of services or facilities from any individual or private entity which has a financial, fiduciary, or other direct interest in the development, expansion, or support of health resources unless, in the case of an entity, it is an organization described in section 509(a) of the Internal Revenue Code of 1954 and is not directly engaged in the provision of health care in the health service area of the agency. For purposes of this paragraph, an entity shall not be considered to have such an interest solely on the basis of its providing (directly or indirectly) health care for its employees. 26 USC 509.

"(6) OTHER REQUIREMENTS.—Each health system agency shall—

"(A) make such reports, in such form and containing such information, concerning its structure, operations, performance of functions, and other matters as the Secretary may from time to time require, and keep such records and afford such access thereto as the Secretary may find necessary to verify such reports; Reports; record-keeping.

"(B) provide for such fiscal control and fund accounting procedures as the Secretary may require to assure proper disbursement of, and accounting for, amounts received from the Secretary under this title and section 1640; and

(C) permit the Secretary and the Comptroller General of the United States, or their representatives, to have access for the purpose of audit and examination to any books, documents, papers, and records pertinent to the disposition of amounts received from the Secretary under this title and section 1640. Post, p. 2273.

"(c) SUBAREA COUNCILS.—A health systems agency may establish subarea advisory councils representing parts of the agencies' health service area to advise the governing body of the agency on the performance of its functions. The composition of a subarea advisory council shall conform to the requirements of subsection (b)(3)(C). Establishment.

"FUNCTIONS OF HEALTH SYSTEMS AGENCIES

"SEC. 1513. (a) For the purpose of— 42 USC 300l-2.

"(1) improving the health of residents of a health service area,

"(2) increasing the accessibility (including overcoming geographic, architectural, and transportation barriers), acceptability, continuity, and quality of the health services provided them,

"(3) restraining increases in the cost of providing them health services, and

"(4) preventing unnecessary duplication of health resources, each health systems agency shall have as its primary responsibility the the provision of effective health planning for its health service area and the promotion of the development within the area of health services, manpower, and facilities which meet identified needs, reduce documented inefficiencies, and implement the health plans of the agency. To meet its primary responsibility, a health systems agency shall carry out the functions described in subsections (b) through (g) of this section.

"(b) In providing health planning and resources development for its health service area, a health systems agency shall perform the following functions:

"(1) The agency shall assemble and analyze data concerning—

"(A) the status (and its determinants) of the health of the residents of its health service area.

"(B) the status of the health care delivery system in the area and the use of that system by the residents of the area,

"(C) the effect the area's health care delivery system has on the health of the residents of the area,

"(D) the number, type, and location of the area's health resources, including health services, manpower, and facilities,

"(E) the patterns of utilization of the area's health resources, and

"(F) the environmental and occupational exposure factors affecting immediate and long-term health conditions.

In carrying out this paragraph, the agency shall to the maximum extent practicable use existing data (including data developed under Federal health programs) and coordinate its activities with the cooperative system provided for under section 306(e). Coordination with cooperative system. 42 USC 242d.

"(2) The agency shall, after appropriate consideration of the recommended national guidelines for health planning policy issued by the Secretary under section 1501, the priorities set forth in section 1502, and the data developed pursuant to paragraph (1), establish, annually review, and amend as necessary a health systems plan (hereinafter in this title referred to as the 'HSP') which shall be a detailed statement of goals (A) describing a healthful environment and health systems in the area which, when developed, will assure that quality health services will be available and accessible in a manner which assures continuity of care, at reasonable cost, for all residents of the area; (B) which are responsive to the unique needs and resources of the area; and (C) which take into account and is consistent with the national guidelines for health planning policy issued by the Secretary under section 1501 respecting supply, distribution, and organization of health resources and services. Before establishing an HSP, a health systems agency shall conduct a public hearing on the proposed HSP and shall give interested persons an opportunity to submit their views orally and in writing. Not less than thirty days prior to such hearing, the agency shall publish in at least two newspapers of general circulation throughout its health service area a notice of its consideration of the proposed HSP, the time and place of the hearing, the place at which interested persons may consult the HSP in advance of the hearing, and the place and period during which to submit written comments to the agency on the HSP. Health systems plan. Establishment. Hearing. Notice.

"(3) The agency shall establish, annually review, and amend as necessary an annual implementation plan (hereinafter in this title referred to as the 'AIP') which describes objectives which Annual implementation plan. Establishment.

will achieve the goals of the HSP and priorities among the objectives. In establishing the AIP, the agency shall give priority to those objectives which will maximally improve the health of the residents of the area, as determined on the basis of the relation of the cost of attaining such objectives to their benefits, and which are fitted to the special needs of the area.

"(4) The agency shall develop and publish specific plans and projects for achieving the objectives established in the AIP.

"(c) A health systems agency shall implement its HSP and AIP, and in implementing the plans it shall perform at least the following functions:

"(1) The agency shall seek, to the extent practicable, to implement its HSP and AIP with the assistance of individuals and public and private entities in its health service area.

"(2) The agency may provide, in accordance with the priorities established in the AIP, technical assistance to individuals and public and private entities for the development of projects and programs which the agency determines are necessary to achieve the health systems described in the HSP, including assistance in meeting the requirements of the agency prescribed under section 1532(b).

"(3) The agency shall, in accordance with the priorities established in the AIP, make grants to public and nonprofit private entities and enter into contracts with individuals and public and nonprofit private entities to assist them in planning and developing projects and programs which the agency determines are necessary for the achievement of the health systems described in the HSP. Such grants and contracts shall be made from the Area Health Services Development Fund of the agency established with funds provided under grants made under section 1640. No grants or contract under this subsection may be used (A) to pay the costs incurred by an entity or individual in the delivery of health services (as defined in regulations of the Secretary), or (B) for the cost of construction or modernization of medical facilities. No single grant or contract made or entered into under this paragraph shall be available for obligation beyond the one year period beginning on the date the grant or contract was made or entered into. If an individual or entity receives a grant or contract under this paragraph for a project or program, such individual or entity may receive only one more such grant or contract for such project or program.

"(d) Each health systems agency shall coordinate its activities with—

"(1) each Professional Standards Review Organization (designated under section 1152 of the Social Security Act),

"(2) entities referred to in paragraphs (1) and (2) of section 204(a) of the Demonstration Cities and Metropolitan Development Act of 1966 and regional and local entities the views of which are required to be considered under regulations prescribed under section 403 of the Intergovernmental Cooperation Act of 1968 to carry out section 401(b) of such Act,

"(3) other appropriate general or special purpose regional planning or administrative agencies, and

"(4) any other appropriate entity,

in the health system agency's health service area. The agency shall, as appropriate, secure data from them for use in the agency's planning and development activities, enter into agreements with them which will assure that actions taken by such entities which alter the area's

Grants and contracts.

Post, p. 2273.

Limitation.

Coordination.

42 USC 1320c-1.

42 USC 3334.

42 USC 4233, 4231.

health system will be taken in a manner which is consistent with the HSP and the AIP in effect for the area, and, to the extent practicable, provide technical assistance to such entities.

Use of Federal funds, approval.

"(e)(1)(A) Except as provided in subparagraph (B), each health systems agency shall review and approve or disapprove each proposed use within its health service area of Federal funds—

"(i) appropriated under this Act, the Community Mental Health Centers Act, or the Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment, and Rehabilitation Act of 1970 for grants, contracts, loans, or loan guarantees for the development, expansion, or support of health resources; or

"(ii) made available by the State in which the health service area is located (from an allotment to the State under an Act referred to in clause (i)) for grants or contracts for the development, expansion, or support of health resources.

42 USC 2681 note.

42 USC 4571.

"(B) A health systems agency shall not review and approve or disapprove the proposed use within its health service area of Federal funds appropriated for grants or contracts under title IV, VII, or VIII of this Act unless the grants or contracts are to be made, entered into, or used to support the development of health resources intended for use in the health service area or the delivery of health services. In the case of a proposed use within the health service area of a health systems agency of Federal funds described in subparagraph (A) by an Indian tribe or inter-tribal Indian organization for any program or project which will be located within or will specifically serve—

"(i) a federally-recognized Indian reservation,

"(ii) any land area in Oklahoma which is held in trust by the United States for Indians or which is a restricted Indian-owned land area, or

"(iii) a Native village in Alaska (as defined in section 3(c) of the Alaska Native Claims Settlement Act),

42 USC 281, 292, 296.

43 USC 1602.

a health systems agency shall only review and comment on such proposed use.

"(2) Notwithstanding any other provision of this Act or any other Act referred to in paragraph (1), the Secretary shall allow a health systems agency sixty days to make the review required by such paragraph. If an agency disapproves a proposed use in its health service area of Federal funds described in paragraph (1), the Secretary may not make such Federal funds available for such use until he has made, upon request of the entity making such proposal, a review of the agency decision. In making any such review of any agency decision, the Secretary shall give the appropriate State health planning and development agency an opportunity to consider the decision of the health systems agency and to submit to the Secretary its comments on the decision. The Secretary, after taking into consideration such State agency's comments (if any), may make such Federal funds available for such use, notwithstanding the disapproval of the health systems agency. Each such decision by the Secretary to make funds available shall be submitted to the appropriate health systems agency and State health planning and development agency and shall contain a detailed statement of the reasons for the decision.

Information to Indian tribes or organizations.

"(3) Each health systems agency shall provide each Indian tribe or inter-tribal Indian organization which is located within the agency's health service area information respecting the availability of the Federal funds described in the first sentence of this subsection.

"(f) To assist State health planning and development agencies in carrying out their functions under paragraphs (4) and (5) of section 1523(a) each health systems agency shall review and make recommen-

dations to the appropriate State health planning and development agency respecting the need for new institutional health services proposed to be offered or developed in the health service area of such health systems agency.

"(g)(1) Except as provided in paragraph (2), each health systems agency shall review on a periodic basis (but at least every five years) all institutional health services offered in the health service area of the agency and shall make recommendations to the State health planning and development agency designated under section 1521 for each State in which the health systems agency's health service area is located respecting the appropriateness in the area of such services.

"(2) A health systems agency shall complete its initial review of existing institutional health services within three years after the date of the agency's designation under section 1515(c).

"(h) Each health systems agency shall annually recommend to the State health planning and development agency designated for each State in which the health systems agency's health service area is located (1) projects for the modernization, construction, and conversion of medical facilities in the agency's health service area which projects will achieve the HSP and AIP of the health systems agency, and (2) priorities among such projects.

"ASSISTANCE TO ENTITIES DESIRING TO BE DESIGNATED AS HEALTH SYSTEMS AGENCIES

"SEC. 1514. The Secretary may provide all necessary technical and other nonfinancial assistance (including the preparation of prototype plans of organization and operation) to nonprofit private entities (including entities presently receiving financial assistance under section 314(b) or title IX or as experimental health service delivery systems under section 304) which—

"(1) express a desire to be designated as health systems agencies, and

"(2) the Secretary determines have a potential to meet the requirements of a health systems agency specified in sections 1512 and 1513.

to assist such entities in developing applications to be submitted to the Secretary under section 1515 and otherwise in preparing to meet the requirements of this part for designation as a health systems agency.

"DESIGNATION OF HEALTH SYSTEMS AGENCIES

"SEC. 1515. (a) At the earliest practicable date after the establishment under section 1511 of health service areas (but not later than eighteen months after the date of enactment of this title) the Secretary shall enter into agreements in accordance with this section for the designation of health systems agencies for such areas.

"(b)(1) The Secretary may enter into agreements with entities under which the entities would be designated as the health systems agencies for health service areas on a conditional basis with a view to determining their ability to meet the requirements of section 1512 (b), and their capacity to perform the functions prescribed by section 1513.

"(2) During any period of conditional designation (which may not exceed 24 months), the Secretary may require that the entity conditionally designated meet only such of the requirements of section 1512(b) and perform only such of the functions prescribed by section 1513 as he determines such entity to be capable of meeting and performing. The number and type of such requirements and functions

Institutional health services, review.

Technical and nonfinancial assistance.
42 USC 3001-3.

42 USC 246, 299, 242b.

Agreements.
42 USC 3001-4.

shall, during the period of conditional designation, be progressively increased as the entity conditionally designated becomes capable of added responsibility so that, by the end of such period, the agency may be considered for designation under subsection (c).

Termination.

"(3) Any agreement under which any entity is conditionally designated as a health systems agency may be terminated by such entity upon ninety days notice to the Secretary or by the Secretary upon ninety days notice to such entity.

Conditional designation.

"(4) The Secretary may not enter into an agreement with any entity under paragraph (1) for conditional designation as a health systems agency for a health service area until—

"(A) the entity has submitted an application for such designation which contains assurances satisfactory to the Secretary that upon completion of the period of conditional designation the applicant will be organized and operated in the manner described in section 1512(b) and will be qualified to perform the functions prescribed by section 1513;

"(B) a plan for the orderly assumption and implementation of the functions of a health systems agency has been received from the applicant and approved by the Secretary; and

"(C) the Secretary has consulted with the Governor of each State in which such health service area is located and with such other State and local officials as he may deem appropriate, with respect to such designation.

In considering such applications, the Secretary shall give priority to an application which has been recommended for approval by each entity which has developed a plan referred to in section 314(b) for all or part of the health service area with respect to which the application was submitted, and each regional medical program established in such area under title IX.

42 USC 246.

42 USC 299.

"(c)(1) The Secretary shall enter into an agreement with an entity for its designation as a health systems agency if, on the basis of an application under paragraph (2) (and, in the case of an entity conditionally designated, on the basis of its performance during a period of conditional designation under subsection (b) as a health systems agency for a health service area), the Secretary determines that such entity is capable of fulfilling, in a satisfactory manner, the requirements and functions of a health systems agency. Any such agreement under this subsection with an entity may be renewed in accordance with paragraph (3), shall contain such provisions respecting the requirements of sections 1512(b) and 1513 and such conditions designed to carry out the purpose of this title, as the Secretary may prescribe, and shall be for a term of not to exceed twelve months; except that, prior to the expiration of such term, such agreement may be terminated—

Renewal.

Termination conditions.

"(A) by the entity at such time and upon such notice to the Secretary as he may by regulation prescribe, or

"(B) by the Secretary, at such time and upon such notice to the entity as the Secretary may by regulation prescribe, if the Secretary determines that the entity is not complying with or effectively carrying out the provisions of such agreement.

Application.

"(2) The Secretary may not enter into an agreement with any entity under paragraph (1) for designation as a health systems agency for a health service area unless the entity has submitted an application to the Secretary for designation as a health systems agency, and the Governor of each State in which the area is located has been consulted respecting such designation of such entity. Such an application shall contain assurances satisfactory to the Secretary that the applicant meets the requirements of section 1512(b) and is qualified to perform

or is performing the functions prescribed by section 1513. In considering such applications, the Secretary shall give priority to an application which has been recommended for approval by (A) each entity which has developed a plan referred to in section 314(b) for all or part of the health service area with respect to which the application was submitted, and (B) each regional medical program established in such area under title IX. Priority. 42 USC 246. 42 USC 299.

"(3) An agreement under this subsection for the designation of a health systems agency may be renewed by the Secretary for a period not to exceed twelve months if upon review (as provided in section 1535) of the agency's operation and performance of its functions, he determines that it has fulfilled, in a satisfactory manner, the functions of a health systems agency prescribed by section 1513 and continues to meet the requirements of section 1512(b). Renewal. Post, p. 2259.

"(d) If a designation under subsection (b) or (c) of a health systems agency for a health services area is terminated before the date prescribed for its expiration, the Secretary shall, upon application and in accordance with subsection (b) or (c) (as the Secretary determines appropriate), enter into a designation agreement with another entity to be the health systems agency for such area.

"PLANNING GRANTS

"SEC. 1516. (a) The Secretary shall make in each fiscal year a grant to each health systems agency with which there is in effect a designation agreement under subsection (b) or (c) of section 1515. A grant under this subsection shall be made on such conditions as the Secretary determines is appropriate, shall be used by a health systems agency for compensation of agency personnel, collection of data, planning, and the performance of the functions of the agency, and shall be available for obligation for a period not to exceed the period for which its designation agreement is entered into or renewed (as the case may be). A health systems agency may use funds under a grant under this subsection to make payments under contracts with other entities to assist the health systems agency in the performance of its functions; but it shall not use funds under such a grant to make payments under a grant or contract with another entity for the development or delivery of health services or resources. 42 USC 300l-5. Use of funds, restriction.

"(b)(1) The amount of any grant under subsection (a) to a health systems agency designated under section 1515(b) shall be determined by the Secretary. The amount of any grant under subsection (a) to any health systems agency designated under section 1515(c) shall be the lesser of—

"(A) the product of $0.50 and the population of the health service area for which the agency is designated, or

"(B) $3,750,000,

unless the agency would receive a greater amount under paragraph (2) or (3).

"(2)(A) If the application of a health systems agency for such a grant contains assurances satisfactory to the Secretary that the agency will expend or obligate in the period in which such grant will be available for obligation non-Federal funds meeting the requirements of subparagraph (B) for the purposes for which such grant may be made, the amount of such grant shall be the sum of— Obligation of non-Federal funds.

"(i) the amount determined under paragraph (1), and

"(ii) the lesser of (I) the amount of such non-Federal funds with respect to which the assurances were made, or (II) the product of $0.25 and the population of the health service area for which the agency is designated.

"(B) The non-Federal funds which an agency may use for the purpose of obtaining a grant under subsection (a) which is computed on the basis of the formula prescribed by subparagraph (A) shall—

"(i) not include any funds contributed to the agency by any individual or private entity which has a financial, fiduciary, or other direct interest in the development, expansion, or support of health resources, and

"(ii) be funds which are not paid to the agency for the performance of particular services by it and which are otherwise contributed to the agency without conditions as to their use other than the condition that the funds shall be used for the purposes for which a grant made under this section may be used.

"(3) The amount of a grant under subsection (a) to a health systems agency designated under section 1515(c) may not be less than $175,000.

"(c)(1) For the purpose of making payments pursuant to grants made under subsection (a), there are authorized to be appropriated $60,000,000 for the fiscal year ending June 30, 1975, $90,000,000 for the fiscal year ending June 30, 1976, and $125,000,000 for the fiscal year ending June 30, 1977. Appropriations.

"(2) Notwithstanding subsection (b), if the total of the grants to be made under this section to health systems agencies for any fiscal year exceeds the total of the amounts appropriated under paragraph (1) for that fiscal year, the amount of the grant for that fiscal year to each health systems agency shall be an amount which bears the same ratio to the amount determined for that agency for that fiscal year under subsection (b) as the total of the amounts appropriated under paragraph (1) for that fiscal year bears to the total amount required to make grants to all health systems agencies in accordance with the applicable provision of subsection (b); except that the amount of any grant to a health systems agency for any fiscal year shall not be less than $175,000, unless the amount appropriated for that fiscal year under paragraph (1) is less than the amount required to make such a grant to each health systems agency.

"PART C—STATE HEALTH PLANNING AND DEVELOPMENT

"DESIGNATION OF STATE HEALTH PLANNING AND DEVELOPMENT AGENCIES

"SEC. 1521. (a) For the purpose of the performance within each State of the health planning and development functions prescribed by section 1523, the Secretary shall enter into and renew agreements (described in subsection (b)) for the designation of a State health planning and development agency for each State other than a State for which the Secretary may not under subsection (d) enter into, continue in effect, or renew such an agreement. Designation agreements. 42 USC 300m.

"(b)(1) A designation agreement under subsection (a) is an agreement with the Governor of a State for the designation of an agency (selected by the Governor) of the government of that State as the State health planning and development agency (hereinafter in this part referred to as the 'State Agency') to administer the State administrative program prescribed by section 1522 and to carry out the State's health planning and development functions prescribed by section 1523. The Secretary may not enter into such an agreement with the Governor of a State unless— Conditions.

"(A) there has been submitted by the State a State administrative program which has been approved by the Secretary,

"(B) an application has been made to the Secretary for such an agreement and the application contains assurances satisfactory

to the Secretary that the agency selected by the Governor for designation as the State Agency has the authority and resources to administer the State administrative program of the State and to carry out the health planning and development functions prescribed by section 1523, and

"(C) in the case of an agreement entered into under paragraph (3), there has been established for the State a Statewide Health Coordinating Council meeting the requirements of section 1524.

"(2)(A) The agreement entered into with a Governor of a State under subsection (a) may provide for the designation of a State Agency on a conditional basis with a view to determining the capacity of the designated State Agency to administer the State administrative program of the State and to carry out the health planning and development functions prescribed by section 1523. The Secretary shall require as a condition to the entering into of such an agreement that the Governor submit on behalf of the agency to be designated a plan for the agency's orderly assumption and implementation of such functions. Plan.

"(B) The period of an agreement described in subparagraph (A) may not exceed twenty-four months. During such period the Secretary may require that the designated State Agency perform only such of the functions of a State Agency prescribed by section 1523 as he determines it is capable of performing. The number and type of such functions shall, during such period, be progressively increased as the designated State Agency becomes capable of added responsibility, so that by the end of such period the designated State Agency may be considered for designation under paragraph (3). Period of agreement.

"(C) Any agreement with a Governor of a State entered into under subparagraph (A) may be terminated by the Governor upon ninety days' notice to the Secretary or by the Secretary upon ninety days' notice to the Governor. Termination.

"(3) If, on the basis of an application for designation as a State Agency (and, in the case of an agency conditionally designated under paragraph (2), on the basis of its performance under an agreement with a Governor of a State entered into under such paragraph), the Secretary determines that the agency is capable of fulfilling, in a satisfactory manner, the responsibilities of a State Agency, he shall enter into an agreement with the Governor of the State designating the agency as the State Agency for the State. No such agreement may be made unless an application therefor is submitted to, and approved by, the Secretary. Any such agreement shall be for a term of not to exceed twelve months, except that, prior to the expiration of such term, such agreement may be terminated— State Agency, designation. Application, submittal to Secretary. Termination.

"(A) by the Governor at such time and upon such notice to the Secretary as he may by regulation prescribe, or

"(B) by the Secretary, at such time and upon such notice to the Governor as the Secretary may by regulation prescribe, if the Secretary determines that the designated State Agency is not complying with or effectively carrying out the provisions of such agreement.

An agreement under this paragraph shall contain such provisions as the Secretary may require to assure that the requirements of this part respecting State Agencies are complied with.

"(4) An agreement entered into under paragraph (3) for the designation of a State Agency may be renewed by the Secretary for a period not to exceed twelve months if he determines that it has fulfilled, in a satisfactory manner, the responsibilities of a State Agency during the period of the agreement to be renewed and if the Renewal.

applicable State administrative program continues to meet the requirements of section 1522.

"(c) If a designation agreement with the Governor of a State entered into under subsection (b)(2) or (b)(3) is terminated before the date prescribed for its expiration, the Secretary shall, upon application and in accordance with subsection (b)(2), or (b)(3) (as the Secretary determines appropriate), enter into another agreement with the Governor for the designation of a State Agency.

"(d) If, upon the expiration of the fourth fiscal year which begins after the calendar year in which the National Health Policy, Planning, and Resources Development Act of 1974 is enacted, an agreement under this section for the designation of a State Agency for a State is not in effect, the Secretary may not make any allotment, grant, loan, or loan guarantee, or enter into any contract, under this Act, the Community Mental Health Centers Act, or the Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment, and Rehabilitation Act of 1970 for the development, expansion, or support of health resources in such State until such time as such an agreement is in effect. 42 USC 2681 note. 42 USC 4571.

"STATE ADMINISTRATIVE PROGRAM

"SEC. 1522. (a) A State administrative program (hereinafter in this section referred to as the 'State Program') is a program for the performance within the State by its State Agency of the functions prescribed by section 1523. The Secretary may not approve a State Program for a State unless it— 42 USC 300m-1. Conditions.

"(1) meets the requirements of subsection (b);

"(2) has been submitted to the Secretary by the Governor of the State at such time and in such detail, and contains or is accompanied by such information, as the Secretary deems necessary; and

"(3) has been submitted to the Secretary only after the Governor of the State has afforded to the general public of the State a reasonable opportunity for a presentation of views on the State Program.

"(b) The State Program of a State must— Functions.

"(1) provide for the performance within the State (after the designation of a State Agency and in accordance with the designation agreement) of the functions prescribed by section 1523 and specify the State Agency of the State as the sole agency for the performance of such functions (except as provided in subsection (b) of such section) and for the administration of the State Program;

"(2) contain or be supported by satisfactory evidence that the State Agency has under State law the authority to carry out such functions and the State Program in accordance with this part and contain a current budget for the operation of the State Agency;

"(3) provide for adequate consultation with, and authority for, the Statewide Health Coordinating Council (prescribed by section 1524), in carrying out such functions and the State Program;

"(4)(A) set forth in such detail as the Secretary may prescribe the qualifications for personnel having responsibilities in the performance of such functions and the State Program, and require the State Agency to have a professional staff for planning and a professional staff for development, which staffs shall be of such size and meet such qualifications as the Secretary may prescribe;

"(B) provide for such methods of administration as are found by the Secretary to be necessary for the proper and efficient administration of such functions and the State Program, including methods relating to the establishment and maintenance of personnel standards on a merit basis consistent with such standards as are or may be established by the Civil Service Commission under section 208(a) of the Intergovernmental Personnel Act of 1970 (Public Law 91-648), but the Secretary shall exercise no authority with respect to the selection, tenure of office, and compensation of any individual employed in accordance with the methods relating to personnel standards on a merit basis established and maintained in conformity with this paragraph; 42 USC 4728.

"(5) require the State Agency to perform its functions in accordance with procedures and criteria established and published by it, which procedures and criteria shall conform to the requirements of section 1532;

"(6) require the State Agency to (A) conduct its business meetings in public, (B) give adequate notice to the public of such meetings, and (C) make its records and data available, upon request, to the public;

"(7)(A) provide for the coordination (in accordance with regulations of the Secretary) with the cooperative system provided for under section 306(e) of the activities of the State Agency for the collection, retrieval, analysis, reporting, and publication of statistical and other information related to health and health care, and (B) require providers of health care doing business in the State to make statistical and other reports of such information to the State Agency; Coordination of information. 42 USC 242d. Reports.

"(8) provide, in accordance with methods and procedures prescribed or approved by the Secretary, for the evaluation, at least annually, of the performance by the State Agency of its functions and of their economic effectiveness; Performance evaluation.

"(9) provide that the State Agency will from time to time, and in any event not less often than annually, review the State Program and submit to the Secretary required modifications; Review of State program.

"(10) require the State Agency to make such reports, in such form and containing such information, concerning its structure, operations, performance of functions, and other matters as the Secretary may from time to time require, and keep such records and afford such access thereto as the Secretary may find necessary to verify such reports; Reports; recordkeeping.

"(11) require the State Agency to provide for such fiscal control and fund accounting procedures as the Secretary may require to assure proper disbursement of, and accounting for, amounts received from the Secretary under this title;

"(12) permit the Secretary and the Comptroller General of the United States, or their representatives, to have access for the purpose of audit and examination to any books, documents, papers, and records of the State Agency pertinent to the disposition of amounts received from the Secretary under this title; and Audit.

"(13) provide that if the State Agency makes a decision in the performance of a function under paragraph (3), (4), (5), or (6) of section 1523(a) or under title XVI which is inconsistent with a recommendation made under subsection (f), (g), or (h) of section 1513 by a health systems agency within the State—

"(A) such decision (and the record upon which it was made) shall, upon request of the health systems agency, be reviewed, under an appeals mechanism consistent with State law governing the practices and procedures of administrative agencies, by an agency of the State (other than the State health planning and development agency) designated by the Governor, and

"(B) the decision of the reviewing agency shall for purposes of this title and title XVI be considered the decision of the State health planning and development agency. Post, p. 2258.

"(c) The Secretary shall approve any State Program and any modification thereof which complies with subsections (a) and (b). The Secretary shall review for compliance with the requirements of this part the specifications of and operations under each State Program approved by him. Such review shall be conducted not less often than once each year. State Program, approval and review.

"STATE HEALTH PLANNING AND DEVELOPMENT FUNCTIONS

"SEC. 1523. (a) Each State Agency of a State designated under section 1521(b)(3) shall, except as authorized under subsection (b), perform within the State the following functions: 42 USC 300m-2.

"(1) Conduct the health planning activities of the State and implement those parts of the State health plan (under section 1524(c)(2)) and the plans of the health systems agencies within the State which relate to the government of the State.

"(2) Prepare and review and revise as necessary (but at least annually) a preliminary State health plan which shall be made up of the HSP's of the health systems agencies within the State. Such preliminary plan may, as found necessary by the State Agency, contain such revisions of such HSP's to achieve their appropriate coordination or to deal more effectively with statewide health needs. Such preliminary plan shall be submitted to the Statewide Health Coordinating Council of the State for approval or disapproval and for use in developing the State health plan referred to in section 1524(c). Preliminary State health plan. Submittal to Statewide Health Coordinating Council.

"(3) Assist the Statewide Health Coordinating Council of the State in the review of the State medical facilities plan required under section 1603, and in the performance of its functions generally. State medical facilities plan, review. Post, p. 2259.

"(4)(A) Serve as the designated planning agency of the State for the purposes of section 1122 of the Social Security Act if the State has made an agreement pursuant to such section, and (B) administer a State certificate of need program which applies to new institutional health services proposed to be offered or developed within the State and which is satisfactory to the Secretary. Such program shall provide for review and determination of need prior to the time such services, facilities, and organizations are offered or developed or substantial expenditures are undertaken in preparation for such offering or development, and provide that only those services, facilities, and organizations found to be needed shall be offered or developed in the State. In performing its functions under this paragraph the State Agency shall consider recommendations made by health systems agencies under section 1513(f). 42 USC 1320a-1.

"(5) After consideration of recommendations submitted by health systems agencies under section 1413(f) respecting new institutional health services proposed to be offered within the State, make findings as to the need for such services.

"(6) Review on a periodic basis (but not less often than every five years) all institutional health services being offered in the

State and, after consideration of recommendations submitted by health systems agencies under section 1513(g) respecting the appropriateness of such services, make public its findings.

"(b)(1) Any function described in subsection (a) may be performed by another agency of the State government upon request of the Governor under an agreement with the State Agency satisfactory to the Secretary.

"(2) The requirement of paragraph (4)(B) of subsection (a) shall not apply to a State Agency of a State until the expiration of the first regular session of the legislature of such State which begins after the date of enactment of this title.

"(3) A State Agency shall complete its findings with respect to the appropriateness of any existing institutional health service within one year after the date a health systems agency has made its recommendation under section 1513(g) with respect to the appropriateness of the service.

"(c) If a State Agency makes a decision in carrying out a function described in paragraph (4), (5), (6), or (7) of subsection (a) which is not consistent with the goals of the applicable HSP or the priorities of the applicable AIP, the State Agency shall submit to the appropriate health systems agency a detailed statement of the reasons for the inconsistency. Statement to health systems agency.

"STATEWIDE HEALTH COORDINATING COUNCIL

"SEC. 1524. (a) A State health planning and development agency designated under section 1521 shall be advised by a Statewide Health Coordinating Council (hereinafter in this section referred to as the 'SHCC') which (1) is organized in the manner described by subsection (b), and (2) performs the functions listed in subsection (c). 42 USC 300m-3.

"(b)(1) A SHCC of a State shall be composed in the following manner: Membership.

"(A)(i) A SHCC shall have no fewer than sixteen representatives appointed by the Governor of the State from lists of at least five nominees submitted to the Governor by each of the health systems agencies designated for health service areas which fall, in whole or in part, within the State.

"(ii) Each such health systems agency shall be entitled to the same number of representatives on the SHCC.

"(iii) Each such health systems agency shall be entitled to at least two representatives on the SHCC. Of the representatives of a health systems agency, not less than one-half shall be individuals who are consumers of health care and who are not providers of health care.

"(B) In addition to the appointments made under subparagraph (A), the Governor of the State may appoint such persons (including State officials, public elected officials, and other representatives of governmental authorities within the State) to serve on the SHCC as he deems appropriate; except that (i) the number of persons appointed to the SHCC under this subparagraph may not exceed 40 per centum of the total membership of the SHCC, and (ii) a majority of the persons appointed by the Governor shall be consumers of health care who are not also providers of health care.

"(C) Not less than one-third of the providers of health care who are members of a SHCC shall be direct providers of health care (as described in section 1531(3)).

"(D) Where two or more hospitals or other health care facilities of the Veterans' Administration are located in a State, the SHCC shall, in addition to the appointed members, include, as an ex officio member, an individual whom the Chief Medical Director of the Veterans' Administration shall have designated as a representative of such facilities.

Chairman. "(2) The SHCC shall select from among its members a chairman.

Meetings. "(3) The SHCC shall conduct all of its business meetings in public, and shall meet at least once in each calendar quarter of a year.

Functions. "(c) A SHCC shall perform the following functions:

Report. "(1) Review annually and coordinate the HSP and AIP of each health systems agency within the State and report to the Secretary, for purposes of his review under section 1535(c), its comments on such HSP and AIP.

"(2)(A) Prepare and review and revise as necessary (but at least annually) a State health plan which shall be made up of the HSP's of the health systems agencies within the State. Such plan may, as found necessary by the SHCC, contain revisions of such HSP's to achieve their appropriate coordination or to deal more effectively with statewide health needs. Each health systems agency which participates in the SHCC shall make available to the SHCC its HSP for each year for integration into the State health plan and shall, as required by the SHCC, revise its HSP to achieve appropriate coordination with the HSP's of the other agencies which participate in the SHCC or to deal more effectively with statewide health needs.

Hearing. "(B) In the preparation and revision of the State health plan, the SHCC shall review and consider the preliminary State health plan submitted by the State agency under section 1523(a)(2), and shall conduct a public hearing on the plan as proposed and shall give interested persons an opportunity to submit their views orally and in writing. Not less than thirty days prior to any such hearing, the SHCC shall publish in at least two newspapers of general circulation in the State a notice of its consideration of the proposed plan, the time and place of the hearing, the place at which interested persons may consult the plan in advance of the hearing, and the place and period during which to direct written comment to the SHCC on the plan.

Budget, review and report. "(3) Review annually the budget of each such health systems agency and report to the Secretary, for purposes of his review under section 1535(a), its comments on such budget.

Applications for grants, review and report. "(4) Review applications submitted by such health systems agencies for grants under sections 1516 and 1640 and report to the Secretary its comments on such applications.

Post, p. 2273.

"(5) Advise the State Agency of the State generally on the performance of its functions.

"(6) Review annually and approve or disapprove any State plan and any application (and any revision of a State plan or application) submitted to the Secretary as a condition to the receipt of any funds under allotments made to States under this Act, the Community Mental Health Centers Act, or the Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment, and Rehabilitation Act of 1970. Notwithstanding any other provision of this Act or any other Act referred to in the preceding sentence, the Secretary shall allow a SHCC sixty days to make the review required by such sentence. If a SHCC disapproves such a State plan or application, the Secretary may not make Federal funds available under such State plan or application until he has made.

42 USC 2681 note.

42 USC 4571.

upon request of the Governor of the State which submitted such plan or application or another agency of such State, a review of the SHCC decision. If after such review the Secretary decides to make such funds available, the decision by the Secretary to make such funds available shall be submitted to the SHCC and shall contain a detailed statement of the reasons for the decision.

"GRANTS FOR STATE HEALTH PLANNING AND DEVELOPMENT

"SEC. 1525. (a) The Secretary shall make grants to State health planning and development agencies designated under subsection (b)(2) or (b)(3) of section 1521 to assist them in meeting the costs of their operation. Any grant made under this subsection to a State Agency shall be available for obligation only for a period not to exceed the period for which its designation agreement is entered into or renewed. The amount of any grant made under this subsection shall be determined by the Secretary, except that no grant to a designated State Agency may exceed 75 per centum of its operation costs (as determined under regulations of the Secretary) during the period for which the grant is available for obligation.

42 USC 300m-4.

Limitation.

"(b) Grants under subsection (a) shall be made on such terms and conditions as the Secretary may prescribe; except that the Secretary may not make a grant to a State Agency unless he receives satisfactory assurances that the State Agency will expend in performing the functions prescribed by section 1523 during the fiscal year for which the grant is sought an amount of funds from non-Federal sources which is at least as great as the average amount of funds expended, in the three years immediately preceding the fiscal year for which such grant is sought, by the State, for which such State Agency has been designated, for the purposes for which funds under such grant may be used (excluding expenditures of a nonrecurring nature).

"(c) For the purpose of making payments under grants under subsection (a), there are authorized to be appropriated $25,000,000 for the fiscal year ending June 30, 1975, $30,000,000 for the fiscal year ending June 30, 1976, and $35,000,000 for the fiscal year ending June 30, 1977.

Appropriations.

"GRANTS FOR RATE REGULATION

"SEC. 1526. (a) For the purpose of demonstrating the effectiveness of State Agencies regulating rates for the provision of health care, the Secretary may make to a State Agency designated, under an agreement entered into under section 1521(b)(3), for a State which (in accordance with regulations prescribed by the Secretary) has indicated an intent to regulate (not later than six months after the date of the enactment of this title) rates for the provision of health care within the State. Not more than six State Agencies may receive grants under this subsection.

42 USC 300m-5.

Limitation.

"(b)(1) A State Agency which receives a grant under subsection (a) shall—

Requirements.

"(A) provide the Secretary satisfactory evidence that the State Agency has under State law the authority to carry out rate regulation functions in accordance with this section and provide the Secretary a current budget for the performance of such functions by it;

"(B) set forth in such detail as the Secretary may prescribe the qualifications for personnel having responsibility in the performance of such functions, and shall have a professional staff for rate regulation, which staff shall be headed by a Director;

"(C) provide for such methods of administration as found by the Secretary to be necessary for the proper and efficient administration of such functions;

"(D) perform its functions in accordance with procedures established and published by it, which procedures shall conform to the requirements of section 1532;

"(E) comply with the requirements prescribed by paragraphs (6) through (12) of section 1522(b) with respect to the functions prescribed by subsection (a);

"(F) provide for the establishment of a procedure under which the State Agency will obtain the recommendation of the appropriate health systems agency prior to conducting a review of the rates charged or proposed to be charged for services; and

"(G) meet such other requirements as the Secretary may prescribe.

"(2) In prescribing requirements under paragraph (1) of this subsection, the Secretary shall consider the manner in which a State Agency shall perform its functions under a grant under subsection (a), including whether the State Agency should—

"(A) permit those engaged in the delivery of health services to retain savings accruing to them from effective management and cost control,

"(B) create incentives at each point in the delivery of health services for utilization of the most economical modes of services feasible,

"(C) document the need for and cost implications of each new service for which a determination of reimbursement rates is sought, and

"(D) employ for each type or class of person engaged in the delivery of health services—

"(i) a unit for determining the reimbursement rates, and

"(ii) a base for determining rates of change in the reimbursement rates,

which unit and base are satisfactory to the Secretary.

Terms and conditions.

"(c) Grants under subsection (a) shall be made on such terms and conditions as the Secretary may prescribe, except that (1) such a grant shall be available for obligation only during the one-year period beginning on the date such grant was made, and (2) no State Agency may receive more than three grants under subsection (a).

Report to Secretary.

"(d) Each State Agency which receives a grant under subsection (a) shall report to the Secretary (in such form and manner as he shall prescribe) on the effectiveness of the rate regulation program assisted by such grant. The Secretary shall report annually to the Congress on the effectiveness of the programs assisted by the grants authorized by subsection (a).

Report to Congress.

Appropriations.

"(e) There are authorized to be appropriated to make payments under grants under subsection (a), $4,000,000 for the fiscal year ending June 30, 1975, $5,000,000 for the fiscal year ending June 30, 1976, and $6,000,000 for the fiscal year ending June 30, 1977.

"PART D—GENERAL PROVISIONS

"DEFINITIONS

42 USC 300n.

"SEC. 1531. For purposes of this title:

"(1) The term 'State' includes the District of Columbia and the Commonwealth of Puerto Rico.

"(2) The term 'Governor' means the chief executive officer of a State or his designee.

"(3) The term 'provider of health care' means an individual—

"(A) who is a direct provider of health care (including a physician, dentist, nurse, podiatrist, or physician assistant) in that the individual's primary current activity is the provision of health care to individuals or the administration of facilities or institutions (including hospitals, long-term care facilities, outpatient facilities, and health maintenance organizations) in which such care is provided and, when required by State law, the individual has received professional training in the provision of such care or in such administration and is licensed or certified for such provision or administration; or

"(B) who is an indirect provider of health care in that the individual—

"(i) holds a fiduciary position with, or has a fiduciary interest in, any entity described in subclause (II) or (IV) of clause (ii);

"(ii) receives (either directly or through his spouse) more than one-tenth of his gross annual income from any one or combination of the following:

"(I) Fees or other compensation for research into or instruction in the provision of health care.

"(II) Entities engaged in the provision of health care or in such research or instruction.

"(III) Producing or supplying drugs or other articles for individuals or entities for use in the provision of or in research into or instruction in the provision of health care.

"(IV) Entities engaged in producing drugs or such other articles.

"(iii) is a member of the immediate family of an individual described in subparagraph (A) or in clause (i), (ii), or (iv) of subparagraph (B); or

"(iv) is engaged in issuing any policy or contract of individual or group health insurance or hospital or medical service benefits.

"(4) the term 'health resources' includes health services, health professions personnel, and health facilities, except that such term does not include Christian Science sanatoriums operated, or listed and certified, by the First Church of Christ, Scientist, Boston, Massachusetts.

"(5) The term 'institutional health services' means the health services provided through health care facilities and health maintenance organizations (as such facilities and organizations are defined in regulations prescribed under section 1122 of the Social Security Act) and includes the entities through which such services are provided. 42 USC 1320a-1.

"PROCEDURES AND CRITERIA FOR REVIEWS OF PROPOSED HEALTH SYSTEM CHANGES

"Sec. 1532. (a) In conducting reviews pursuant to subsections (e), (f), and (g) of section 1513 or in conducting any other reviews of proposed or existing health services, each health systems agency shall (except to the extent approved by the Secretary) follow procedures, and apply criteria, developed and published by the agency in accordance with regulations of the Secretary; and in performing its review functions under section 1523, a State Agency shall (except to the extent approved by the Secretary) follow procedures, and apply criteria, developed and published by the State Agency in accordance with regulations of the Secretary. Procedures and criteria for reviews by 42 USC 300n-1.

health systems agencies and States Agencies may vary according to the purpose for which a particular review is being conducted or the type of health services being reviewed.

Requirements.

"(b) Each health systems agency and State Agency shall include in the procedures required by subsection (a) at least the following:

"(1) Written notification to affected persons of the beginning of a review.

"(2) Schedules for reviews which provide that no review shall, to the extent practicable, take longer than ninety days from the date the notification described in paragraph (1) is made.

"(3) Provision for persons subject to a review to submit to the agency or State Agency (in such form and manner as the agency or State Agency shall prescribe and publish) such information as the agency or State Agency may require concerning the subject of such review.

"(4) Submission of applications (subject to review by a health systems agency or a State Agency) made under this Act or other provisions of law for Federal financial assistance for health services to the health systems agency or State Agency at such time and in such manner as it may require.

"(5) Submission of periodic reports by providers of health services and other persons subject to agency or State Agency review respecting the development of proposals subject to review.

"(6) Provision for written findings which state the basis for any final decision or recommendation made by the agency or State Agency.

"(7) Notification of providers of health services and other persons subject to agency or State Agency review of the status of the agency or State Agency review of the health services or proposals subject to review, findings made in the course of such review, and other appropriate information respecting such review.

"(8) Provision for public hearings in the course of agency or State Agency review if requested by persons directly affected by the review; and provision for public hearings, for good cause shown, respecting agency and State Agency decisions.

"(9) Preparation and publication of regular reports by the agency and State Agency of the reviews being conducted (including a statement concerning the status of each such review) and of the reviews completed by the agency and State Agency (including a general statement of the findings and decisions made in the course of such reviews) since the publication of the last such report.

"(10) Access by the general public to all applications reviewed by the agency and State Agency and to all other written materials pertinent to any agency or State Agency review.

"(11) In the case of construction projects, submission to the agency and State Agency by the entities proposing the projects of letters of intent in such detail as may be necessary to inform the agency and State Agency of the scope and nature of the projects at the earliest possible opportunity in the course of planning of such construction projects.

"(c) Criteria required by subsection (a) for health systems agency and State Agency review shall include consideration of at least the following:

"(1) The relationship of the health services being reviewed to the applicable HSP and AIP.

"(2) The relationship of services reviewed to the long-range development plan (if any) of the person providing or proposing such services.

"(3) The need that the population served or to be served by such services has for such services.

"(4) The availability of alternatives, less costly, or more effective methods of providing such services.

"(5) The relationship of services reviewed to the existing health care system of the area in which such services are provided or proposed to be provided.

"(6) In the case of health services proposed to be provided, the availability of resources (including health manpower, management personnel, and funds for capital and operating needs) for the provision of such services and the availability of alternative uses of such resources for the provision of other health services.

"(7) The special needs and circumstances of those entities which provide a substantial portion of their services or resources, or both, to individuals not residing in the health service areas in which the entities are located or in adjacent health service areas. Such entities may include medical and other health professions schools, multidisciplinary clinics, specialty centers, and such other entities as the Secretary may by regulation prescribe.

"(8) The special needs and circumstances of health maintenance organizations for which assistance may be provided under title XIII. 42 USC 300e.

"(9) In the case of a construction project—

"(A) the costs and methods of the proposed construction, and

"(B) the probable impact of the construction project reviewed on the costs of providing health services by the person proposing such construction project.

"TECHNICAL ASSISTANCE FOR HEALTH SYSTEMS AGENCIES AND STATE HEALTH PLANNING AND DEVELOPMENT AGENCIES

"Sec. 1533. (a) The Secretary shall provide (directly or through grants or contracts, or both) to designated health systems agencies and State Agencies (1) assistance in developing their health plans and approaches to planning various types of health services, (2) technical materials, including methodologies, policies, and standards appropriate for use in health planning, and (3) other technical assistance as may be necessary in order that such agencies may properly perform their functions. 42 USC 300n-2.

"(b) The Secretary shall include in the materials provided under subsection (a) the following:

"(1)(A) Specification of the minimum data needed to determine the health status of the residents of a health service area and the determinants of such status.

"(B) Specification of the minimum data needed to determine the status of the health resources and services of a health service area.

"(C) Specification of the minimum data needed to describe the use of health resources and services within a health service area.

"(2) Planning approaches, methodologies, policies, and standards which shall be consistent with the guidelines established by the Secretary under section 1501 for appropriate planning and development of health resources, and which shall cover the priorities listed in section 1502. Ante, p. 2227.

"(3) Guidelines for the organization and operation of health systems agencies and State Agencies including guidelines for— Guidelines.

"(A) the structure of a health systems agency, consistent with section 1512(b), and of a State Agency, consistent with section 1522;

"(B) the conduct of the planning and development processes;

"(C) the performance of health systems agency functions in accordance with section 1513; and

"(D) the performance of State Agency functions in accordance with section 1523.

National health planning information center. Establishment.

"(c) In order to facilitate the exchange of information concerning health services, health resources, and health planning and resources development practice and methodology, the Secretary shall establish a national health planning information center to support the health planning and resources development programs of health systems agencies, State Agencies, and other entities concerned with health planning and resources development; to provide access to current information on health planning and resources development; and to provide information for use in the analysis of issues and problems related to health planning and resources development.

"(d) The Secretary shall establish the following within one year of the date of enactment of this title:

Operation cost system.

"(1) A uniform system for calculating the aggregate cost of operation and the aggregate volume of services provided by health services institutions as defined by the Secretary in regulations. Such system shall provide for the calculation of the aggregate volume to be based on:

"(A) The number of patient days;

"(B) The number of patient admissions;

"(C) The number of out-patient visits; and

"(D) Other relevant factors as determined by the Secretary.

Cost accounting system.

"(2) A uniform system for cost accounting and calculating the volume of services provided by health services institutions. Such system shall:

"(A) Include the establishment of specific cost centers and, where appropriate, subcost centers.

"(B) Include the designation of an appropriate volume factor for each cost center.

"(C) Provide for an appropriate application of such system in the different types of institutions (including hospitals, nursing homes, and other types of health services institutions), and different sizes of such types of institutions.

Rates, calculation system.

"(3) A uniform system for calculating rates to be charged to health insurers and other health institutions payors by health service institutions. Such system shall:

"(A) Be based on an all-inclusive rate for various categories of patients (including, but not limited to individuals receiving medical, surgical, pediatric, obstetric, and psychiatric institutional health services).

"(B) Provide that such rates reflect the true cost of providing services to each such category of patients. The system shall provide that revenues derived from patients in one category shall not be used to support the provision of services to patients in any other category.

"(C) Provide for an appropriate application of such system in the different types of institutions (including hospitals, nursing homes, and other types of health service institutions) and different sizes of such types of institutions.

"(D) Provide that differences in rates to various classes of purchasers (including health insurers, direct service pay-

ors, and other health institution payors) be based on justified and documented differences in the costs of operation of health service institutions made possible by the actions of such purchasers.

"(4) A classification system for health services institutions. Such classification system shall quantitatively describe and group health services institutions of the various types. Factors included in such classification system shall include— Classification system.

"(A) the number of beds operated by an institution;

"(B) the geographic location of an institution;

"(C) the operation of a postgraduate physician training program by an institution; and

"(D) the complexity of services provided by an institution.

"(5) A uniform system for the reporting by health services institutions of— Reporting system.

"(A) the aggregate cost of operation and the aggregate volume of services, as calculated in accordance with the system established by the Secretary under paragraph (1);

"(B) the costs and volume of services at various cost centers, and subcost centers, as calculated in accordance with the system established by the Secretary under paragraph (2); and

"(C) rates, by category of patient and class of purchaser, as calculated in accordance with the system established by the Secretary under paragraph (3).

Such system shall provide for an appropriate application of such system in the different types of institutions (including hospitals, nursing homes, and other types of health services institutions) and different sizes of such institutions.

"CENTERS FOR HEALTH PLANNING

"SEC. 1534. (a) For the purposes of assisting the Secretary in carrying out this title, providing such technical and consulting assistance as health systems agencies and State Agencies may from time to time require, conducting research, studies and analyses of health planning and resources development, and developing health planning approaches, methodologies, policies, and standards, the Secretary shall by grants or contracts, or both, assist public or private nonprofit entities in meeting the costs of planning and developing new centers, and operating existing and new centers, for multidisciplinary health planning development and assistance. To the extent practicable, the Secretary shall provide assistance under this section so that at least five such centers will be in operation by June 30, 1976. 42 USC 300n-3.

"(b)(1) No grant or contract may be made under this section for planning or developing a center unless the Secretary determines that when it is operational it will meet the requirements listed in paragraph (2) and no grant or contract may be made under this section for operation of a center unless the center meets such requirements.

"(2) The requirements referred to in paragraph (1) are as follows: Requirements.

"(A) There shall be a full-time director of the center who possesses a demonstrated capacity for substantial accomplishment and leadership in the field of health planning and resources development, and there shall be such additional professional staff as may be appropriate.

"(B) The staff of the center shall represent a diversity of relevant disciplines.

"(C) Such additional requirements as the Secretary may by regulation prescribe.

"(c) Centers assisted under this section (1) may enter into arrangements with health systems agencies and State Agencies for the provision of such services as may be appropriate and necessary in assisting the agencies and State Agencies in performing their functions under section 1513 or 1523, respectively, and (2) shall use methods (satisfactory to the Secretary) to disseminate to such agencies and State Agencies such planning approaches, methodoligies, policies and standards as they develop.

"(d) For the purpose of making payments pursuant to grants and contracts under subsection (a) there are authorized to be appropriated $5,000,000 for the fiscal year ending June 30, 1975, $8,000,000 for the fiscal year ending June 30, 1976, and $10,000,000 for the fiscal year ending June 30, 1977. Appropriations.

"REVIEW BY THE SECRETARY

"SEC. 1535. (a) The Secretary shall review and approve or disapprove the annual budget of each designated health systems agency and State Agency. In making such review and approval or disapproval the Secretary shall consider the comments of Statewide Health Coordinating Councils submitted under section 1524(c)(3). Information submitted to the Secretary by a health systems agency or a State Agency in connection with the Secretary's review under this subsection shall be made available by the Secretary, upon request, to the appropriate committees (and their subcommittees) of the Congress. Budget, review and approval. 42 USC 300n-4.

"(b) The Secretary shall prescribe performance standards covering the structure, operation, and performance of the functions of each designated health systems agency and State Agency, and he shall establish a reporting system based on the performance standards that allows for continuous review of the structure, operation, and performance of the functions of such agencies. Performance standards.

"(c) The Secretary shall review in detail at least every three years the structure, operation, and performance of the functions of each designated health systems agency to determine—

"(1) the adequacy of the HSP of the agency for meeting the needs of the residents of the area for a healthful environment and for accessible, acceptable and continuous quality health care at reasonable costs, and the effectiveness of the AIP in achieving the system described in the HSP;

"(2) if the structure, operation, and performance of the functions of the agency meet the requirements of sections 1512(b) and 1513; Ante, p. 2232.

"(3) the extent to which the agency's governing body (and executive committee (if any)) represents the residents of the health service area for which the agency is designated;

"(4) the professional credentials and competence of the staff of the agency;

"(5) the appropriateness of the data assembled pursuant to section 1513(b)(1) and the quality of the analyses of such data;

"(6) the extent to which technical and financial assistance from the agency have been utilized in an effective manner to achieve goals and objectives of the HSP and the AIP; and

"(7) the extent to which it may be demonstrated that—

"(A) the health of the residents in the agency's health service area has been improved;

"(B) the accessibility, acceptability, continuity, and quality of health care in such area has been improved; and

"(C) increases in costs of the provision of health care have been restrained.

"(d) The Secretary shall review in detail at least every three years the structure, operation, and performance of the functions of each designated State Agency to determine—

"(1) the adequacy of the State health plan of the Statewide Health Coordinating Council prepared under section 1524(c)(2) in meeting the needs of the residents of the State for a healthful environment and for accessible, acceptable, and continuous quality health care at reasonable costs;

"(2) if the structure, operation, and performance of the functions of the State Agency meet the requirements of sections 1522 and 1523;

"(3) the extent to which the Statewide Health Coordinating Council has a membership meeting, and has performed in a manner consistent with, the requirements of section 1524;

"(4) the professional credentials and competence of the staff of the State Agency;

"(5) the extent to which financial assistance provided under title XVI by the State Agency has been used in an effective manner to achieve the State's health plan under section 1524(c)(2); and

"(6) the extent to which it may be demonstrated that—

"(A) the health of the residents of the State has been improved;

"(B) the accessibility, acceptability, continuity, and quality of health care in the State has been improved; and

"(C) increases in costs of the provision of health care have been restrained.

"SPECIAL PROVISIONS FOR CERTAIN STATES AND TERRITORIES

"SEC. 1536. (a) Any State which— 42 USC 300n-5.

"(1) has no county or municipal public health institution or department, and

"(2) has, prior to the date of enactment of this title, maintained a health planning system which substantially complies with the purposes of this title,

and the Virgin Islands, Guam, the Trust Territories in the Pacific Islands, and American Samoa shall each be considered in accordance with subsection (b) to be a State for purposes of this title.

"(b) In the case of an entity which under subsection (a) is to be considered a State for purposes of this title—

"(1) no health service area shall be established within it,

"(2) no health systems agency shall be designated for it,

"(3) the State Agency designated for it under section 1521 may, in addition to the functions prescribed by section 1523, perform the functions prescribed by section 1513 and shall be eligible to receive grants authorized by sections 1516 and 1640, and

"(4) the chief executive office shall appoint the Statewide Health Coordinating Council prescribed by section 1524 in accordance with the regulation of the Secretary."

REVISION OF HEALTH RESOURCES DEVELOPMENT PROGRAMS UNDER THE PUBLIC HEALTH SERVICE ACT

SEC. 4. The Public Health Service Act, as amended by section 3, is amended by adding after title XV the following new title: Ante, p. 2227.

"TITLE XVI—HEALTH RESOURCES DEVELOPMENT

"PART A—PURPOSE, STATE PLAN, AND PROJECT APPROVAL

"PURPOSE

42 USC 300o. "SEC. 1601. It is the purpose of this title to provide assistance, Post, p. 2262. through allotments under part B and loans and loan guarantees Post, p. 2264. and interest subsidies under part C, for projects for—

"(1) modernization of medical facilities;

"(2) construction of new outpatient medical facilities;

"(3) construction of new inpatient medical facilities in areas which have experienced (as determined under regulations of the Secretary) recent rapid population growth; and

"(4) conversion of existing medical facilities for the provision of new health services,

and to provide assistance, through grants under part D, for construction and modernization projects designed to prevent or eliminate safety hazards in medical facilities or to avoid noncompliance by such facilities with licensure or accreditation standards.

"GENERAL REGULATIONS

42 USC 300o-1. "SEC. 1602. The Secretary shall by regulation—

"(1) prescribe the general manner in which the State Agency of each State shall determine for the State medical facilities plan under section 1603 the priority among projects within the State for which assistance is available under this title, based on the relative need of different areas within the State for such projects and giving special consideration—

"(A) to projects for medical facilities serving areas with relatively small financial resources and for medical facilities serving rural communities,

"(B) in the case of projects for modernization of medical facilities, to projects for facilities serving densely populated areas,

"(C) in the case of projects for construction of outpatient medical facilities, to projects that will be located in, and provide services for residents of, areas determined by the Secretary to be rural or urban poverty areas,

"(D) to projects designed to (i) eliminate or prevent imminent safety hazards as defined by Federal, State, or local fire, building, or life safety codes or regulations, or (ii) avoid noncompliance with State or voluntary licensure or accreditation standards, and

"(E) to projects for medical facilities which, alone or in conjunction with other facilities, will provide comprehensive health care, including outpatient and preventive care as well as hospitalization;

"(2) prescribe for medical facilities projects assisted under this title general standards of construction, modernization, and equipment for medical facilities of different classes and in different types of location;

"(3) prescribe criteria for determining needs for medical facility beds and needs for medical facilities, and for developing plans for the distribution of such beds and facilities;

"(4) prescribe criteria for determining the extent to which existing medical facilities are in need of modernization;

"(5) require each State medical facilities plan under section 1503 to provide for adequate medical facilities for all persons residing in the State and adequate facilities to furnish needed health services for persons unable to pay therefor; and

"(6) prescribe the general manner in which each entity which receives financial assistance under this title or has received financial assistance under this title or title VI shall be required to comply with the assurances required to be made at the time such assistance was received and the means by which such entity shall be required to demonstrate compliance with such assurances. 42 USC 291.

An entity subject to the requirements prescribed pursuant to paragraph (6) respecting compliance with assurances made in connection with receipt of financial assistance shall submit periodically to the Secretary data and information which reasonably supports the entity's compliance with such assurances. The Secretary may not waive the requirement of the preceding sentence.

"STATE MEDICAL FACILITIES PLAN

"SEC. 1603. (a) Before an application for assistance under this title (other than part D) for a medical facility project described in section 1601 may be approved, the State Agency of the State in which such project is located must have submitted to the Secretary and had approved by him a State medical facilities plan. To be approved by the Secretary a State medical facilities plan for a State must— 42 USC 300o-2. Post, p. 2260.

"(1) prescribe that the State Agency of the State shall administer or supervise the administration of the plan and contain evidence satisfactory to the Secretary that the State Agency has the authority to carry out the plan in conformity with this title;

"(2) prescribe that the Statewide Health Coordinating Council of the State shall advise and consult with the State Agency in carrying out the plan;

"(3) be approved by the Statewide Health Coordinating Council as consistent with the State health plan developed pursuant to section 1524(c)(2);

"(4) set forth, in accordance with criteria established in regulations prescribed under section 1602(a) and on the basis of a statewide inventory of existing medical facilities, a survey of need, and the plans of health systems agencies within the State—

"(A) the number and type of medical facility beds and medical facilities needed to provide adequate inpatient care to people residing in the State, and a plan for the distribution of such beds and facilities in health services areas throughout the State,

"(B) the number and type of outpatient and other medical facilities needed to provide adequate public health services and outpatient care to people residing in the State, and a plan for the distribution of such facilities in health service areas throughout the State, and

"(C) the extent to which existing medical facilities in the State are in need of modernization or conversion to new uses;

"(5) set forth a program for the State for assistance under this title for projects described in section 1601, which program shall indicate the type of assistance which should be made available to each project and shall conform to the assessment of need set forth pursuant to paragraph (4) and regulations promulgated under section 1602(a);

"(6) set forth (in accordance with regulations promulgated under section 1602(a)) priorities for the provision of assistance under this title for projects in the program set forth pursuant to paragraph (4);

"(7) provide minimum requirements (to be fixed in the discretion of the State Agency) for the maintenance and operation of facilities which receive assistance under this title, and provide for enforcement of such standards;

"(8) provide for affording to every applicant for assistance for a medical facilities project under this title an opportunity for a hearing before the State Agency; and

"(9) provide that the State Agency will from time to time, but not less often than annually, review the plan and submit to the Secretary any modifications thereof which it considers necessary.

"(b) The Secretary shall approve any State medical facilities plan and any modification thereof which complies with the provisions of subsection (a) if the State Agency, as determined under the review made under section 1535(d), is organized and operated in the manner prescribed by section 1522 and is carrying out its functions under section 1523 in a manner satisfactory to the Secretary. If any such plan or modification thereof shall have been disapproved by the Secretary for failure to comply with subsection (a), the Secretary shall, upon request of the State Agency, afford it an opportunity for hearing.

"APPROVAL OF PROJECTS

"SEC. 1604. (a) For each project described in section 1601 and included within a State's State medical facilities plan approved under section 1603 there shall be submitted to the Secretary, through the State's State Agency, an application. An application for a grant under section 1625 shall be submitted directly to the Secretary. Except as provided in section 1625, the applicant under such an application may be a State, a political subdivision of a State or any other public entity, or a private nonprofit entity. If two or more entities join in a project, an application for such project may be filed by any of such entities or by all of them. 42 USC 300o-3.

Application requirements.

"(b)(1) Except as authorized under paragraph (2), an application for any project shall set forth—

"(A) in the case of a modernization project for a medical facility for continuation of existing health services, a finding by the State Agency of a continued need for such services, and, in the case of any other project for a medical facility, a finding by the State Agency of the need for the new health services to be provided through the medical facility upon completion of the project;

"(B) a description of the site of such project;

"(C) plans and specifications therefor which meet the requirements of the regulations prescribed under section 1602(a);

"(D) reasonable assurance that title to such site is or will be vested in one or more of the entities filing the application or in a public or other nonprofit entity which is to operate the facility on completion of the project;

"(E) reasonable assurance that adequate financial support will be available for the completion of the project and for its maintenance and operation when completed, and, for the purpose of determining if the requirements of this subparagraph are met, Federal assistance provided directly to a medical facility which is located in an area determined by the Secretary to be an urban or rural poverty area or through benefits provided individuals served at such facility shall be considered as financial support;

"(F) the type of assistance being sought under this title for the project;

"(G) except in the case of a project under section 1625, a certification by the State Agency of the Federal share for the project;

"(H) reasonable assurance that all laborers and mechanics employed by contractors or subcontractors in the performance of work on a project will be paid wages at rates not less than those prevailing on similar construction in the locality as determined by the Secretary of Labor in accordance with the Act of March 3, 1931 (40 U.S.C. 276a—276a-5, known as the Davis-Bacon Act), and the Secretary of Labor shall have with respect to such labor standards the authority and functions set forth in Reorganization Plan Numbered 14 of 1950 (15 F.R. 3176; 5 U.S.C. Appendix) and section 2 of the Act of June 13, 1934 (40 U.S.C. 276c); 40 USC 276a note.

"(I) in the case of a project for the construction or modernization of an outpatient facility, reasonable assurance that the services of a general hospital will be available to patients at such facility who are in need of hospital care; and

"(J) reasonable assurance that at all times after such application is approved (i) the facility or portion thereof to be constructed, or modernized, or converted will be made available to all persons residing or employed in the area served by the facility, and (ii) there will be made available in the facility or portion thereof to be constructed, modernized, or converted a reasonable volume of services to persons unable to pay therefor and the Secretary, in determining the reasonableness of the volume of services provided, shall take into consideration the extent to which compliance is feasible from a financial viewpoint.

"(2)(A) The Secretary may waive— Waiver.

"(i) the requirements of subparagraph (C) of paragraph (1) for compliance with modernization and equipment standards prescribed pursuant to section 1602(a)(2), and

"(ii) the requirement of subparagraph (D) of paragraph (1) respecting title to a project site,

in the case of an application for a project described in subparagraph (B).

"(B) A project referred to in subparagraph (A) is a project—

"(i) for the modernization of an outpatient medical facility which will provide general purpose health services, which is not part of a hospital, and which will serve a medically underserved population as defined in section 1653 or as designated by a health systems agency, and

"(ii) for which the applicant seeks (I) not more than $20,000 from the allotments made under part B to the State in which it is located, or (II) a loan under part C the principal amount of which does not exceed $20,000. Post, p. 2262. Post, p. 2264.

"(c) The Secretary shall approve an application submitted under subsection (b) (other than an application for a grant under section 1625) if—

"(1) in the case of a project to be assisted from an allotment made under part B, there are sufficient funds in such allotment to pay the Federal share of the project; and

"(2) the Secretary finds that—

"(A) the application (i) is in conformity with the State medical facilities plan approved under section 1603, (ii) has been approved and recommended by the State Agency, (iii) is for a project which is entitled to priority over other projects within the State as determined in accordance with the

approved State medical facilities plan, and (iv) contains the assurances required by subsection (b); and

"(B) the plans and specifications for the project meet the requirements of the regulations prescribed pursuant to section 1602(a).

"(d) No application (other than an application for a grant under section 1625) shall be disapproved until the Secretary has afforded the State Agency an opportunity for a hearing.

"(e) Amendment of any approved application shall be subject to approval in the same manner as an original application.

"(f) Each application shall be reviewed by health systems agencies in accordance with section 1513(c). Ante, p. 2235.

"PART B—ALLOTMENTS

"ALLOTMENTS

42 USC 300p. "SEC. 1610. (a) For each fiscal year, the Secretary shall, in accordance with regulations, make from sums appropriated for such fiscal year under section 1513 allotments among the States on the basis of the population, the financial need, and need for medical facilities projects described in section 1601 of the respective States. The population of the States shall be determined on the basis of the latest figures certified by the Secretary of Commerce.

Limitation. "(b)(1) The allotment to any State (other than Guam, American Samoa, the Virgin Islands, or the Trust Territory of the Pacific Islands) for any fiscal year shall be not less than $1,000,000; and the allotment to Guam, American Samoa, the Virgin Islands, and the Trust Territory of the Pacific Islands for any fiscal year shall be not less than $500,000 each.

"(2) Notwithstanding paragraph (1), if the amount appropriated under section 1613 for any fiscal year is less than the amount required to provide allotments in accordance with paragraph (1), the amount of the allotment to any State for such fiscal year shall be an amount which bears the same ratio to the amount prescribed for such State by paragraph (1) as the amount appropriated for such fiscal year bears to the amount of appropriations needed to make allotments to all the States in accordance with paragraph (1).

"(c) Any amount allotted to a State for a fiscal year under subsection (a) and remaining unobligated at the end of such year shall remain available to such State, for the purpose for which made, for the next two fiscal years (and for such years only), in addition to the amounts allotted to such State for such purposes for such next two fiscal years; except that any such amount which is unobligated at the end of the first of such next two years and which the Secretary determines will remain unobligated at the close of the second of such next two years may be reallotted by the Secretary, to be available for the purposes for which made until the close of the second of such next two years, to other States which have need therefor, on such basis as the Secretary deems equitable and consistent with the purposes of this title. Any amount so reallotted to a State shall be in addition to the amounts allotted and available to the State for the same period.

"PAYMENTS FROM ALLOTMENTS

42 USC 300p-1. "SEC. 1611. (a) If with respect to any medical facility project approved under section 1604 the State Agency certifies (upon the basis of inspection by it) to the Secretary that, in accordance with approved plans and specifications, work has been performed upon

the project or purchases have been made for it and that payment from the applicable allotment of the State in which the project is located is due for the project, the Secretary shall, except as provided in subsection (b), make such payment to the State.

"(b) The Secretary is authorized to not make payments to a State pursuant to subsection (a) in the following circumstances: Payment restriction.

"(1) If such State is not authorized by law to make payments for an approved medical facility project from the payment to be made by the Secretary pursuant to subsection (a), or if the State so requests, the Secretary shall make the payment from the State allotment directly to the applicant for such project.

"(2) If the Secretary, after investigation or otherwise, has reason to believe that any act (or failure to act) has occurred requiring action pursuant to section 1612, payment by the Secretary may, after he has given the State Agency notice and opportunity for hearing pursuant to such section, be withheld, in whole or in part, pending corrective action or action based on such hearing.

In no event may the total of payments made under subsection (a) with respect to any project exceed an amount equal to the Federal share of such project.

"(c) In case an amendment to an approved application is approved as provided in section 1604 or the estimated cost of a project is revised upward, any additional payment with respect thereto may be made from the applicable allotment of the State for the fiscal year in which such amendment or revision is approved.

"(d) In any fiscal year—

"(1) not more than 20 per centum of the amount of a State's allotment available for obligation in that fiscal year may be obligated for projects in the State for construction of new facilities for the provision of inpatient health care to persons residing in areas of the State which have experienced recent rapid population growth; and

"(2) not less than 25 per centum of the amount of a State's allotment available for obligation in that fiscal year shall be obligated for projects for outpatient facilities which will serve medically underserved populations.

In the administration of this part, the Secretary shall seek to assure that in each fiscal year at least one half of the amount obligated for projects pursuant to paragraph (2) shall be obligated for projects which will serve rural medically underserved populations. Rural projects.

"WITHHOLDING OF PAYMENTS AND OTHER COMPLIANCE ACTIONS

"SEC. 1612. (a) Whenever the Secretary, after reasonable notice and opportunity for hearing to the State Agency concerned finds— 42 USC 300p-2.

"(1) that the State Agency is not complying substantially with the provisions required by section 1603 to be included in its State medical facilities plan,

"(2) that any assurance required to be given in an application filed under section 1604 is not being or cannot be carried out, or

"(3) that there is a substantial failure to carry out plans and specifications approved by the Secretary under section 1604,

the Secretary shall take the action authorized by subsection (b) unless, in the case of compliance with assurances, the Secretary requires compliance by other means authorized by law.

"(b)(1) Upon a finding described in subsection (a) and after notice to the State Agency concerned, the Secretary may—

"(A) withhold from all projects within the State with respect to which the finding was made further payments from the State's allotment under section 1610, or

"(B) withhold from the specific projects with respect to which the finding was made further payments from the applicable State allotment under section 1610.

"(2) Payments may be withheld, in whole or in part, under paragraph (1)—

"(A) until the basis for the finding upon which the withholding was made no longer exists, or

"(B) if corrective action to make such finding inapplicable cannot be made, until the State concerned repays or arranges for the repayment of Federal funds paid under this part for projects which because of the finding are not entitled to such funds.

"(c) The Secretary shall investigate and ascertain, on a periodic basis, with respect to each entity which is receiving financial assistance under this title or which has received financial assistance under title VI or this title, the extent of compliance by such entity with the assurances required to be made at the time such assistance was received. If the Secretary finds that such an entity has failed to comply with any such assurance, the Secretary shall take the action authorized by subsection (b) or take any other action authorized by law (including an action for specific performance brought by the Attorney General upon request of the Secretary) which will effect compliance by the entity with such assurances. An appropriate action to effectuate compliance with any such assurance may be brought by a person other than the Secretary only if a complaint has been filed by such person with the Secretary and the Secretary has dismissed such complaint or the Attorney General has not brought a civil action for compliance with such assurance within 6 months after the date on which the complaint was filed with the Secretary. Periodic investigations. 42 USC 291.

"AUTHORIZATION OF APPROPRIATIONS

"SEC. 1613. Except as provided in section 1625(d), there are authorized to be appropriated for allotments under section 1510 $125,000,000 for the fiscal year ending June 30, 1975, $130,000,000 for the fiscal year ending June 30, 1976, and $135,000,000 for the fiscal year ending June 30, 1977. 42 USC 300p-3.

"PART C—LOANS AND LOAN GUARANTEES

"AUTHORITY FOR LOANS AND LOAN GUARANTEES

"SEC. 1620. (a) The Secretary, during the period beginning July 1, 1974, and ending June 30, 1977, may, in accordance with this part, make loans from the fund established under section 1622(d) to pay the Federal share of projects approved under section 1604. 42 USC 300q.

"(b)(1) The Secretary, during the period beginning July 1, 1974, and ending June 30, 1977, may, in accordance with this part, guarantee to—

"(i) non-Federal lenders for their loans to nonprofit private entities for medical facilities projects, and

"(ii) the Federal Financing Bank for its loans to nonprofit private entities for such projects,

payment of principal and interest on such loans if applications for assistance for such projects under this title have been approved under section 1604.

"(2) In the case of a guarantee of any loan to a nonprofit private entity under this title, the Secretary shall pay, to the holder of such loan and for and on behalf of the project for which the loan was made amounts sufficient to reduce by 3 per centum per annum the net effective interest rate otherwise payable on such loan. Each holder of such a loan which is guaranteed under this title shall have a contractual right to receive from the United States interest payments required by the preceding sentence. Interest payments.

"(c) The cumulative total of the principal of the loans outstanding at any time with respect to which guarantees have been issued, or which have been directly made, may not exceed such limitations as may be specified in appropriation Acts. Limitations.

"(d) The Secretary, with the consent of the Secretary of Housing and Urban Development, shall obtain from the Department of Housing and Urban Development such assistance with respect to the administration of this part as will promote efficiency and economy thereof. HUD assistance.

"ALLOCATION AMONG THE STATES

"SEC. 1621. (a) For each fiscal year, the total amount of principal of— 42 USC 300q-1.

"(1) loans to nonprofit private entities which may be guaranteed, or

"(2) loans which may be directly made,

under this part shall be allotted by the Secretary among the States, in accordance with regulations, on the basis of the population, financial need, and need for medical facilities projects described in section 1601 of the respective States. The population of the States shall be determined on the basis of the latest figures certified by the Secretary of Commerce.

"(b) Any amount allotted to a State for a fiscal year under subsection (a) and remaining unobligated at the end of such year shall remain available to such State, for the purpose for which made, for the next two fiscal years (and for such years only), in addition to the amounts allotted to such State for such purposes for such next two fiscal years; except that any such amount which is unobligated at the end of the first of such next two years and which the Secretary determines will remain unobligated at the close of the second of such next two years may be reallotted by the Secretary, to be available for the purposes for which made until the close of the second of such next two years, to other States which have need therefor, on such basis as the Secretary deems equitable and consistent with the purposes of this title. Any amount so reallotted to a State shall be in addition to the amounts allotted and available to the State for the same period. Unobligated funds, availability to State. Reallotments.

"GENERAL PROVISIONS RELATING TO LOAN GUARANTEES AND LOANS

"SEC. 1622. (a)(1) The Secretary may not approve a loan guarantee for a project under this part unless he determines that (A) the terms, conditions, security (if any), and schedule and amount of repayments with respect to the loan are sufficient to protect the financial interests of the United States and are otherwise reasonable, including a determination that the rate of interest does not exceed such per centum per annum on the principal obligation outstanding as the Secretary determines to be reasonable, taking into account the range of interest rates prevailing in the private market for similar loans and the risks assumed by the United States, and (B) the loan would not be available on reasonable terms and conditions without the guarantee under this part. 42 USC 300q-2.

"(2)(A) The United States shall be entitled to recover from the applicant for a loan guarantee under this part the amount of any payment made pursuant to such guarantee, unless the Secretary for good cause waives such right of recovery; and, upon making any such payment, the United States shall be subrogated to all of the rights of the recipient of the payments with respect to which the guarantee was made. Payment recovery.

"(B) To the extent permitted by subparagraph (C), any terms and conditions applicable to a loan guarantee under this part (including terms and conditions imposed under subparagraph (D)) may be modified by the Secretary to the extent he determines it to be consistent with the financial interest of the United States. Terms and conditions, modification.

"(C) Any loan guarantee made by the Secretary under this part shall be incontestable (i) in the hands of an applicant on whose behalf such guarantee is made unless the applicant engaged in fraud or misrepresentation in securing such guarantee, and (ii) as to any person (or his successor in interest) who makes or contracts to make a loan to such applicant in reliance thereon unless such person (or his successor in interest) engaged in fraud or misrepresentation in making or contracting to make such loan.

"(D) Guarantees of loans under this part shall be subject to such further terms and conditions as the Secretary determines to be necessary to assure that the purposes of this title will be achieved.

"(b)(1) The Secretary may not approve a loan under this part unless— Loan approval conditions.

"(A) the Secretary is reasonably satisfied that the applicant under the project for which the loan would be made will be able to make payments of principal and interest thereon when due, and

"(B) the applicant provides the Secretary with reasonable assurances that there will be available to it such additional funds as may be necessary to complete the project or undertaking with respect to which such loan is requested.

"(2) Any loan made under this part shall (A) have such security, (B) have such maturity date, (C) be repayable in such installments, (D) bear interest at a rate comparable to the current rate of interest prevailing, on the date the loan is made, with respect to loans guaranteed under this part, minus 3 per centum per annum, and (E) be subject to such other terms and conditions (including provisions for recovery in case of default), as the Secretary determines to be necessary to carry out the purposes of this title while adequately protecting the financial interests of the United States.

"(3) The Secretary may, for good cause but with due regard to the financial interests of the United States, waive any right of recovery which he has by reasons of the failure of a borrower to make payments of principal of and interest on a loan made under this part, except that if such loan is sold and guaranteed, any such waiver shall have no effect upon the Secretary's guarantee of timely payment of principal and interest. Waiver.

"(c)(1) The Secretary shall from time to time, but with due regard to the financial interests of the United States, sell loans made under this part either on the private market or to the Federal National Mortgage Association in accordance with section 302 of the Federal National Mortgage Association Charter Act or to the Federal Financing Bank. Sale of loans. 12 USC 1717.

"(2) Any loan so sold shall be sold for an amount which is equal (or approximately equal) to the amount of the unpaid principal of such loans as of time of sale.

"(3)(A) The Secretary is authorized to enter into an agreement with the purchaser of any loan sold under this part under which the Secretary agrees— Agreements with loan purchaser.

"(i) to guarantee to such purchaser (and any successor in interest to such purchaser) payments of the principal and interest payable under such loan, and

"(ii) to pay as an interest subsidy to such purchaser (and any successor in interest of such purchaser) amounts which, when added to the amount of interest payable on such loan, are equivalent to a reasonable rate of interest on such loan as determined by the Secretary after taking into account the range of prevailing interest rates in the private market on similar loans and the risks assumed by the United States.

"(B) Any agreement under subparagraph (A)—

"(i) may provide that the Secretary shall act as agent of any such purchaser, for the purpose of collecting from the entity to which such loan was made and paying over to such purchaser any payments of principal and interest payable by such entity under such loan;

"(ii) may provide for the repurchase by the Secretary of any such loan on such terms and conditions as may be specified in the agreement;

"(iii) shall provide that, in the event of any default by the entity to which such loan was made in payment of principal or interest due on such loan, the Secretary shall, upon notification to the purchaser (or to the successor in interest of such purchaser), have the option to close out such loan (and any obligations of the Secretary with respect thereto) by paying to the purchaser (or his successor in interest) the total amount of outstanding principal and interest due thereon at the time of such notification; and

"(iv) shall provide that, in the event such loan is closed out as provided in clause (iii), or in the event of any other loss incurred by the Secretary by reason of the failure of such entity to make payments of principal or interest on such loan, the Secretary shall be subrogated to all rights of such purchaser for recovery of such loan from such entity.

"(4) Amounts received by the Secretary as proceeds from the sale of loans under this subsection shall be deposited in the fund established under subsection (d).

"(d)(1) There is established in the Treasury a loan and loan guarantee fund (hereinafter in this subsection referred to as the 'fund') which shall be available to the Secretary without fiscal year limitation, in such amounts as may be specified from time to time in appropriation Acts— Loan and guarantee fund. Establishment.

"(A) to enable him to make loans under this part.

"(B) to enable him to discharge his responsibilities under loan guarantees issued by him under this part,

"(C) for payment of interest under section 1620(b)(2) on loans guaranteed under this part.

"(D) for repurchase of loans under subsection (c)(3)(B), and

"(E) for payment of interest on loans which are sold and guaranteed.

There are authorized to be appropriated from time to time such amounts as may be necessary to provide the sums required for the fund. There shall also be deposited in the fund amounts received by the Secretary in connection with loans and loan guarantees under this part and other property or assets derived by him from his operations Appropriation.

respecting such loans and loan guarantees, including any money derived from the sale of assets.

"(2) If at any time the sums in the funds are insufficient to enable the Secretary—

"(A) to make payments of interest under section 1620(b)(2),

"(B) to otherwise comply with guarantees under this part of loans to nonprofit private entities,

"(C) in the case of a loan which was made, sold, and guaranteed under this part, to make to the purchaser of such loan payments of principal and interest on such loan after default by the entity to which the loan was made, or

"(D) to repurchase loans under subsection (c)(3)(B), and

"(E) to make payments of interest on loans which are sold and guaranteed,

he is authorized to issue to the Secretary of the Treasury notes or other obligations in such forms and denominations, bearing such maturities, and subject to such terms and conditions, as may be prescribed by the Secretary with the approval of the Secretary of the Treasury. Such notes or other obligations shall bear interest at a rate determined by the Secretary of the Treasury, taking into consideration the current average market yield on outstanding marketable obligations of the United States of comparable maturities during the month preceding the issuance of the notes or other obligations. The Secretary of the Treasury shall purchase any notes and other obligations issued under this paragraph and for that purpose he may use as a public debt transaction the proceeds from the sale of any securities issued under the Second Liberty Bond Act, and the purposes for which the securities may be issued under that Act are extended to include any purchase of such notes and obligations. The Secretary of the Treasury may at any time sell any of the notes or other obligations acquired by him under this paragraph. All redemptions, purchases, and sales by the Secretary of the Treasury of such notes or other obligations shall be treated as a public debt transactions of the United States. Sums borrowed under this paragraph shall be deposited in the fund and redemption of such notes and obligations shall be made by the Secretary from the fund. Notes or other obligations. 31 USC 774.

"(e)(1) The assets, commitments, obligations, and outstanding balances of the loan guarantee and loan fund established in the Treasury by section 626 shall be transferred to the fund established by subsection (d) of this section. Transfer of funds. 42 USC 2913-6.

"(2) To provide additional capitalization for the fund established under subsection (d) there are authorized to be appropriated to the fund, such sums as may be necessary for the fiscal years ending June 30, 1975, June 30, 1976, and June 30, 1977. Appropriation.

"PART D—PROJECT GRANTS

"PROJECT GRANTS

"SEC. 1625. (a) The Secretary may make grants for construction or modernization projects designed to (1) eliminate or prevent imminent safety hazards as defined by Federal, State, or local fire, building, or life safety codes or regulations, or (2) avoid noncompliance with State or voluntary licensure or accreditation standards. A grant under this subsection may only be made to a State or political subdivision of a State, including any city, town, county, borough, hospital district authority, or public or quasi-public corporation, for a project described in the preceding sentence for any medical facility owned or operated by it. 42 USC 300r.

"(b) An application for a grant under subsection (a) may not be approved under section 1604 unless it contains assurances satisfactory to the Secretary that the applicant making the application would not be able to complete the project for which the application is submitted without the grant applied for.

"(c) The amount of any grant under subsection (a) may not exceed 75 per centum of the cost of the project for which the grant is made unless the project is located in an area determined by the Secretary to be an urban or rural poverty area, in which case the grant may cover up to 100 per centum of such costs. Cost limitation.

"(d) Of the sums appropriated under section 1613 for a fiscal year, there shall be made available for grants under subsection (a) for such fiscal year 22 per centum of such sums.

"PART E—GENERAL PROVISIONS

"JUDICIAL REVIEW

"SEC. 1630. If— 42 USC 300s.

"(1) the Secretary refuses to approve an application for a project submitted under section 1604, the State Agency through which such application was submitted, or

"(2) any State is dissatisfied with, or any entity will be adversely affected by, the Secretary's action under section 1612, such State or entity,

may appeal to the United States court of appeals for the circuit in which such State Agency, State, or entity is located, by filing a petition with such court within sixty days after such action. A copy of the petition shall be forthwith transmitted by the clerk of the court to the Secretary, or any officer designated by him for that purpose. The Secretary thereupon shall file in the court the record of the proceedings on which he based his action, as provided in section 2112 of title 28, United States Code. Upon the filing of such petition, the court shall have jurisdiction to affirm the action of the Secretary or to set it aside, in whole or in part, temporarily or permanently, but until the filing of the record, the Secretary may modify or set aside his order. The findings of the Secretary as to the facts, if supported by substantial evidence, shall be conclusive, but the court, for good cause shown, may remand the case to the Secretary to take further evidence, and the Secretary may thereupon make new or modified findings of fact and may modify his previous action, and shall file in the court the record of the further proceedings. Such new or modified findings of fact shall likewise be conclusive if supported by substantial evidence. The judgment of the court affirming or setting aside, in whole or in part, any action of the Secretary shall be final, subject to review by the Supreme Court of the United States upon certiorari or certification as provided in section 1254 of title 28, United States Code. The commencement of proceedings under this section shall not, unless so specifically ordered by the Court, operate as a stay of the Secretary's action. Filing of petition. Modified findings of fact.

"RECOVERY

"SEC. 1631. (a) If any facility constructed, modernized, or converted with funds provided under this title is, at any time within twenty years after the completion of such construction, modernization, or conversion with such funds— 42 USC 300s-1.

"(1) sold or transferred to any person or entity (A) which is not qualified to file an application under section 1604, or (B) which is not approved as a transferee by the State Agency of the State in which such facility is located, or its successor; or

"(2) not used as a medical facility, and the Secretary has not determined that there is good cause for termination of such use,

the United States shall be entitled to recover from either the transferor or the transferee in the case of a sale or transfer or from the owner in the case of termination of use an amount bearing the same ratio to the then value (as determined by the agreement of the parties or by action brought in the district court of the United States for the district in which the facility is situated) of so much of such facility as constituted an approved project or projects, as the amount of the Federal participation bore to the cost of the construction, modernization, or conversion of such project or projects. Such right of recovery shall not constitute a lien upon such facility prior to judgment.

"(b) The Secretary may waive the recovery rights of the United States under subsection (a) with respect to a facility in any State— Waiver.

"(1) if (as determined under regulations prescribed by the Secretary) the amount which could be recovered under subsection (a) with respect to such facility is applied to the development, expansion, or support of another medical facility located in such State which has been approved by the Statewide Health Coordinating Council for such State as consistent with the State health plan established pursuant to section 1524(c); or Ante, p. 2247.

"(2) if the Secretary determines, in accordance with regulations, that there is good cause for waiving such requirement with respect to such facility.

If the amount which the United States is entitled to recover under subsection (a) exceeds 90 per centum of the total cost of the construction or modernization project for a facility, a waiver under this subsection shall only apply with respect to an amount which is not more than 90 per centum of such total cost. The Secretary may not waive a right of recovery which arose one year before the date of the enactment of this title.

"STATE CONTROL OF OPERATIONS

"SEC. 1632. Except as otherwise specifically provided, nothing in this title shall be construed as conferring on any Federal officer or employee the right to exercise any supervision or control over the administration, personnel, maintenance, or operation of any facility with respect to which any funds have been or may be expended under this title. 42 USC 300s-2.

"DEFINITIONS

"SEC. 1633. For the purposes of this title— 42 USC 300s-3.

"(1) The term 'State' includes the Commonwealth of Puerto Rico, Guam, American Samoa, the Trust Territory of the Pacific Islands, the Virgin Islands, and the District of Columbia.

"(2) The term 'Federal share' means the proportion of the cost of a medical facilities project which the State Agency determines the Federal Government will provide under allotment payments or a loan or loan guarantee under this title, except that—

"(A) in the case of a modernization project—

"(i) described in section 1604(b)(2)(B), and

"(ii) the application for which received a waiver under section 1604(b)(2)(A),

the proportion of the cost of such project to be paid by the Federal Government under allotment payments or a loan may not exceed $80,000 and may not exceed 100 per centum of the first $6,000 of the cost of such project and 66⅔ per centum of the next $21,000 of such cost,

"(B) in the case of a project (other than a project described in subparagraph (A)) to be assisted from an allotment made under part B, the proportion of the cost of such project to be paid by the Federal Government may not exceed 66⅔ unless the project is located in an area determined by the Secretary to be an urban or rural poverty area, in which case the proportion of the cost of such project to be paid by the Federal Government may be 100 per centum, and

"(C) in the case of a project (other than a project described in subparagraph (A)) to be assisted with a loan or loan guarantee made under part C, the principal amount of the loan directly made or guaranteed for such project, when added to any other assistance provided the project under this title, may not exceed 90 per centum of the cost of such project unless the project is located in an area determined by the Secretary to be an urban or rural poverty area, in which case the principal amount, when added to other assistance under this title, may cover up to 100 per centum of the cost of the project.

"(3) The term 'hospital' includes general, tuberculosis, and other types of hospitals, and related facilities, such as laboratories, outpatient departments, nurses' home facilities, extended care facilities, facilities related to programs for home health services, self-care units, and central service facilities, operated in connection with hospitals, and also includes education or training facilities for health professional personnel operated as an integral part of a hospital, but does not include any hospital furnishing primarily domiciliary care.

"(4) The term 'public health center' means a publicly owned facility for the provision of public health services, including related publicly owned facilities such as laboratories, clinics, and administrative offices operated in connection with such a facility.

"(5) The term 'nonprofit' as applied to any facility means a facility which is owned and operated by one or more nonprofit corporations or associations no part of the net earnings of which inures, or may lawfully inure, to the benefit of any private shareholder or individual.

"(6) The term 'outpatient medical facility' means a medical facility (located in or apart from a hospital) for the diagnosis or diagnosis and treatment of ambulatory patients (including ambulatory inpatients)—

"(A) which is operated in connection with a hospital,

"(B) in which patient care is under the professional supervision of persons licensed to practice medicine or surgery in the State, or in the case of dental diagnosis or treatment, under the professional supervision of persons licensed to practice dentistry in the State; or

"(C) which offers to patients not requiring hospitalization the services of licensed physicians in various medical specialties, and which provides to its patients a reasonably full-range of diagnostic and treatment services.

"(7) The term 'rehabilitation facility' means a facility which is operated for the primary purpose of assisting in the rehabilitation of disabled persons through an integrated program of—

"(A) medical evaluation and services, and

"(B) psychological, social, or vocational evaluation and services,

under competent professional supervision, and in the case of which the major portion of the required evaluation and services is furnished within the facility; and either the facility is operated in connection with a hospital, or all medical and related health services are prescribed by, or are under the general direction of, persons licensed to practice medicine or surgery in the State.

"(8) The term 'facility for long-term care' means a facility (including a skilled nursing or intermediate care facility) providing in-patient care for convalescent or chronic disease patients who required skilled nursing or intermediate care and related medical services—

"(A) which is a hospital (other than a hospital primarily for the care and treatment of mentally ill or tuberculous patients) or is operated in connection with a hospital, or

"(B) in which such care and medical services are prescribed by, or are performed under the general direction of, persons licensed to practice medicine or surgery in the State.

"(9) The term 'construction' means construction of new buildings and initial equipment of such buildings and, in any case in which it will help to provide a service not previously provided in the community, equipment of any buildings; including architects' fees, but excluding the cost of off-site improvements and, except with respect to public health centers, the cost of the acquisition of land.

"(10) The term 'cost' as applied to construction, modernization, or conversion means the amount found by the Secretary to be necessary for construction, modernization, or conversion, respectively, under a project, except that, in the case of a modernization project or a project assisted under part D, such term does not include any amount found by the Secretary to be attributable to expansion of the bed capacity of any facility.

Ante, p. 2268.

"(11) The term 'modernization' includes the alteration, expansion, major repair (to the extent permitted by regulations), remodeling, replacement, and renovation of existing buildings (including initial equipment thereof), and the replacement of obsolete equipment of existing buildings.

"(12) The term 'title,' when used with reference to a site for a project, means a fee simple, or such other estate or interest (including a leasehold on which the rental does not exceed 4 per centum of the value of the land) as the Secretary finds sufficient to assure for a period of not less than twenty-five years' undisturbed use and possession for the purposes of construction, modernization, or conversion and operation of the project for a period of not less than (A) twenty years in the case of a project assisted under an allotment or grant under this title, or (B) the term of repayment of a loan made or guaranteed under this title in the case of a project assisted by a loan or loan guarantee.

"(13) The term 'medical facility' means a hospital, public health center, outpatient medical facility, rehabilitation facility, facility for long-term care, or other facility (as may be designated by the Secretary) for the provision of health care to ambulatory patients.

"(14) The term 'State Agency' means the State health planning and development agency of a State designated under title XIV.

42 USC 1351.

"(15) The term 'urban or rural poverty area' means an urban or rural geographical area (as defined by the Secretary) in which a percentage (as defined by the Secretary in accordance with the next sentence) of the residents of the area have incomes below the poverty level (as defined by the Secretary of Commerce). The percentage referred to in the preceding sentence shall be defined so that the percentage of the population of the United States residing in urban and rural poverty areas is—

"(A) not more than the percentage of the total population of the United States with incomes below the poverty level (as so defined) plus five per centum, and

"(B) not less than such percentage minus five per centum.

"(16) The term 'medically underserved population' means the population of an urban or rural area designated by the Secretary as an area with a shortage of health facilities or a population group designated by the Secretary as having a shortage of such facilities.

"FINANCIAL STATEMENTS; RECORDS AND AUDIT

"SEC. 1634. (a) In the case of any facility for which an allotment payment, grant, loan, or loan guarantee has been made under this title, the applicant for such payment, grant, loan, or loan guarantee (or, if appropriate, such other person as the Secretary may prescribe) shall file at least annually with the State Agency for the State in which the facility is located a statement which shall be in such form, and contain such information, as the Secretary may require to accurately show— 42 USC 300s-4.

"(1) the financial operations of the facility, and

"(2) the costs to the facility of providing health services in the facility and the charges made by the facility for providing such services,

during the period with respect to which the statement is filed.

"(b)(1) Each entity receiving Federal assistance under this title shall keep such records as the Secretary shall prescribe, including records which fully disclose the amount and disposition by such entity of the proceeds of such assistance, the total cost of the project in connection with which such assistance is given or used, the amount of that portion of the cost of the project supplied by other sources, and such other records as will facilitate an effective audit. Record-keeping.

"(2) The Secretary and the Comptroller General of the United States, or any of their duly authorized representatives, shall have access for the purpose of audit and examination to any books, documents, papers, and records of such entities which in the opinion of the Secretary or the Comptroller General may be related or pertinent to the assistance referred to in paragraph (1). Audit.

"(c) Each such entity shall file at least annually with the Secretary a statement which shall be in such form, and contain such information, as the Secretary may require to accurately show—

"(1) the financial operations of the facility constructed or modernized with such assistance, and

"(2) the costs to such facility of providing health services in such facility, and the charges made for such services, during the period with respect to which the statement is filed.

"TECHNICAL ASSISTANCE

"SEC. 1635. The Secretary shall provide (either through the Department of Health, Education, and Welfare or by contract) all necessary technical and other nonfinancial assistance to any public or other nonprofit entity which is eligible to apply for assistance under this title to assist such entity in developing applications to be submitted to the Secretary under section 1604. The Secretary shall make every effort to inform eligible applicants of the availability of assistance under this title. 42 USC 300s-5.

"PART F—AREA HEALTH SERVICES DEVELOPMENT FUNDS

"DEVELOPMENT GRANTS FOR AREA HEALTH SERVICES DEVELOPMENT FUNDS

"SEC. 1640. (a) The Secretary shall make in each fiscal year a grant to each health system agency— 42 USC 300t.

"(1) with which there is in effect a designation agreement under section 1515(c), Ante, p. 2239.

"(2) which has in effect an HSP and AIP reviewed by the Statewide Health Coordinating Council, and

"(3) which, as determined under the review made under section 1535(c), is organized and operated in the manner prescribed by section 1512(b) and is performing its functions under section 1513 in a manner satisfactory to the Secretary, Ante, p. 2256. Ante, p. 2232. Ante, p. 2235.

to enable the agency to establish and maintain an Area Health Services Development Fund from which it may make grants and enter into contracts in accordance with section 1513(c)(3).

"(b)(1) Except as provided in paragraph (2), the amount of any grant under subsection (a) shall be determined by the Secretary after taking into consideration the population of the health service area for which the health systems agency is designated, the average family income of the area, and the supply of health services in the area.

Limitation. "(2) The amount of any grant under subsection (a) to a health systems agency for any fiscal year may not exceed the product of $1 and the population of the health service area for which such agency is designated.

"(c) No grant may be made under subsection (a) unless an application therefor has been submitted to, and approved by, the Secretary. Such an application shall be submitted in such form and manner and contain such information as the Secretary may require.

Appropriations. "(d) For the purpose of making payments pursuant to grants under subsection (a), there are authorized to be appropriated $25,000,000 for the fiscal year ending June 30, 1975, $75,000,000 for the fiscal year ending June 30, 1976, and $120,000,000 for the fiscal year ending June 30, 1977."

MISCELLANEOUS AND TRANSITIONAL PROVISIONS

Appropriations. 42 USC 300s note. SEC. 5. (a)(1) There are authorized to be appropriated for the fiscal year ending June 30, 1975, and the next fiscal year such sums as may be necessary to make grants under section 314(a) of the Public Health Service Act, except that no grant made to a State with funds appropriated under this paragraph shall be available for obligation beyond— 42 USC 246.

(A) three months after the date on which a State health planning and development agency is designated for such State under section 1421 of such Act, or Ante, p. 2242.

(B) June 30, 1976,

whichever is later.

(2) There are authorized to be appropriated for the fiscal year ending June 30, 1975, and the next fiscal year such sums as may be necessary to make grants under section 304 of the Public Health Service Act for experimental health services delivery systems, section 314(b) of such Act, and title IX of such Act, except that no grant made with funds appropriated under this paragraph shall be available for obligation beyond the later of (A) June 30, 1976, or (B) three months after the date on which a health systems agency has been designated under section 1515 of such Act for a health service area which includes the area of the entity for which a grant is made under such section 304, 314(b), or title IX. 42 USC 3001-4 note. 42 USC 242b. 42 USC 299.

(b) Any State which has in the fiscal year ending June 30, 1975, or the next fiscal year funds available for obligation from its allotments under part A of title VI of the Public Health Service Act may in such fiscal year use for the proper and efficient administration during such year of its State plan approved under such part an amount of such funds which does not exceed 4 per centum of such funds or $100,000, whichever is less. 42 USC 291b note. 42 USC 291a.

(c) A reference in any law or regulation—

(1) to the agency of a State which administers or supervises the administration of a State's health planning functions under a State plan approved under section 314(a) of the Public Health Service Act shall in the case of a State for which a State Health planning and development agency has been designated under section 1521 of such Act be considered a reference to the State agency designated under such section 1521;

(2) to an agency or organization which has developed a comprehensive regional, metropolitan, or other local area plan or plans referred to in section 314(b) of the Public Health Service Act shall if all or part of the area covered by such plan or plans is within a health service area established under section 1511 of the Public Health Service Act be considered a reference to the health systems agency designated under section 1515 of such Act for such health service area; and

(3) to a regional medical program assisted under title IX of the Public Health Service Act shall if the program is located in a State for which a State health planning and development agency has been designated under section 1521 of the Public Health Service Act be considered a reference to such State agency.

(d) Section 316 of the Public Health Service Act is repealed.

42 USC 300m note.
42 USC 246.
Ante, p. 2242.
42 USC 300l-4 note.
Ante, p. 2229.
Ante, p. 2239.
42 USC 300m note.
42 USC 299.
Repeal.
42 USC 247a.

ADVISORY COMMITTEE

SEC. 6. (a) An advisory committee established by or pursuant to the Public Health Service Act, the Mental Retardation Facilities and Community Mental Health Centers Construction Act of 1963, or the Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment, and Rehabilitation Act of 1970 shall terminate at such time as may be specifically prescribed by an Act of Congress enacted after the date of the enactment of this Act.

(b) The Secretary of Health, Education, and Welfare shall report, within one year after the date of the enactment of this Act, to the Committee on Labor and Public Welfare of the Senate and the Committee on Interstate and Foreign Commerce of the House of Representatives (1) the purpose and use of each advisory committee established by or pursuant to the Public Health Service Act, the Mental Retardation Facilities and Community Mental Health Centers Construction Act of 1963, or the Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment, and Rehabilitation Act of 1970 and (2) his recommendations respecting the termination of each such advisory committee.

Termination.
42 USC 217a note.
42 USC 201 note.
42 USC 2661 note.
42 USC 4571.
Reports to congressional committees.

AGENCY REPORTS

SEC. 7. The Secretary of Health, Education, and Welfare shall report, within one year of the date of the enactment of this Act, to the Committee on Labor and Public Welfare of the Senate and the Committee on Interstate and Foreign Commerce of the House of Representatives (1) the identity of each report required to be made by the Secretary under the Public Health Service Act, the Mental Retardation Facilities and Community Mental Health Centers Construction Act of 1963, or the Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment, and Rehabilitation Act of 1970 to the Congress (or any committee thereof), (2) the provision of such Acts which requires each such report, (3) the purpose of each such report, and (4) the due date for each such report. The report of the

Report to congressional committees.
42 USC 229 note.

Secretary under this section may include such recommendations as he considers appropriate for termination or consolidation of any such reporting requirements.

TECHNICAL AMENDMENT

SEC. 8. Section 1305(b)(1) of the Public Health Service Act is amended to read as follows:

"(b)(1) Except as provided in paragraph (2), the aggregate amount of principal of loans made or guaranteed, or both, under this section for a health maintenance organization may not exceed $2,500,000. In any fiscal year, the amount disbursed under a loan or loans made or guaranteed under this section for a health maintenance organization may not exceed $1,000,000,000."

42 USC 300e-4.

Approved January 4, 1975.

LEGISLATIVE HISTORY:

HOUSE REPORTS: No. 93-1382 accompanying H.R. 16204 (Comm. on Interstate and Foreign Commerce) and No. 93-1640 (Comm. of Conference).
SENATE REPORT No. 93-1285 (Comm. on Labor and Public Welfare).
CONGRESSIONAL RECORD, Vol. 120 (1974):
Nov. 25, considered and passed Senate.
Dec. 13, considered and passed House, amended, in lieu of H.R. 16204.
Dec. 19, Senate agreed to conference report.
Dec. 20, House agreed to conference report.

APPENDIX D

THE EMERGENCY HEALTH SERVICES SYSTEMS ACT OF 1973

95th Congress
2d Session } COMMITTEE PRINT { COMMITTEE PRINT 95-38

COMPILATION OF SELECTED ACTS WITHIN THE JURISDICTION OF THE COMMITTEE ON INTERSTATE AND FOREIGN COMMERCE

VOLUME I

HEALTH LAW

INCLUDING

PUBLIC HEALTH SERVICE ACT

MENTAL RETARDATION FACILITIES AND COMMUNITY MENTAL HEALTH CENTERS CONSTRUCTION ACT OF 1963

COMPREHENSIVE ALCOHOL ABUSE AND ALCOHOLISM PREVENTION, TREATMENT, AND REHABILITATION ACT OF 1970

DRUG ABUSE OFFICE AND TREATMENT ACT OF 1972

PREPARED FOR THE USE OF THE

HOUSE COMMITTEE ON INTERSTATE AND FOREIGN COMMERCE

1978

Printed for the use of the
House Committee on Interstate and Foreign Commerce

TITLE XII—EMERGENCY MEDICAL SERVICES SYSTEMS

DEFINITIONS

PART A—ASSISTANCE FOR EMERGENCY MEDICAL SERVICES SYSTEMS

42 U.S.C. 300d

SEC. 1201. For purposes of this part:

(1) The term "emergency medical services system" means a system which provides for the arrangement of personnel, facilities, and equipment for the effective and coordinated delivery in an appropriate geographical area of health care services under emergency conditions (occurring either as a result of the patient's condition or of natural disasters or similar situations) and which is administered by a public or nonprofit private entity which has the authority and the resources to provide effective administration of the system.

(2) The term "State" includes the District of Columbia, the Commonwealth of Puerto Rico, the Northern Mariana Islands, the Virgin Islands, Guam, American Samoa, and the Trust Territory of the Pacific Islands.

(3) The term "modernization" means the alteration, major repair (to the extent permitted by regulations), remodeling, and renovation of existing buildings (including initial equipment thereof), and replacement of obsolete, built-in (as determined in accordance with regulations) equipment of existing buildings.

(4) The term "section 1521 State health planning and development agency" means the agency of a State designated under section 1521(b)(3).

(5) The term "section 1515 health systems agency" means a health systems agency designated under section 1515, and the term "health systems plan" means a health systems plan referred to in section 1513(b)(2).

GRANTS AND CONTRACTS FOR FEASIBILITY STUDIES AND PLANNING

42 U.S.C. 300d-1

SEC. 1202. (a) (1) The Secretary may make grants to and enter into contracts with eligible entities (as defined in section 1206(a)) for projects which include both

studying the feasibility of and planning (A) the establishment and operation of an emergency medical services system, (B) the expansion and improvement of such a system, or (C) both.

(2) If the Secretary makes a grant or enters into a contract under this section for a study and planning project respecting an emergency medical services system for a particular geographical area, the Secretary may not make any other grant or enter into any other contract under paragraph (1) for such project, and he may not make a grant or enter into a contract under paragraph (1) for any other study and planning project respecting an emergency medical services system for the same area or for an area which includes (in whole or substantial part) such area.

(b)(1) The Secretary may make a grant to or enter into a contract with an eligible entity (as defined in section 1206(a)) with respect to an emergency medical services system for the purpose of enabling the entity—

(A) to study the feasibility of, or plan for, the expansion and improvement of such system to provide for the use in such system of advanced life-support techniques, or

(B) if such system is the system of a State for which system a study and planning grant or contract has been made or entered into under subsection (a) and if the entity is that State, to update the plan of such system to improve the delivery of emergency medical services in rural areas and to medically underserved populations of the State.

(2) If the Secretary makes a grant or enters into a contract under paragraph (1) respecting an emergency medical services system for a particular geographical area, the Secretary may not make any other grant or enter into any other contract under paragraph (1) respecting such system, or respecting any other such system for the same area or for an area which includes (in whole or substantial part) such area.

(c) An eligible entity which has received a grant from or entered into a contract with the Secretary under this section shall submit to the Secretary and the Interagency Committee on Emergency Medical Services (established under section 1209) a report on the results of such grant or contract at such intervals as the Secretary may prescribe, and shall submit to the Secretary and such Committee a final report on the results of such grant or contract not later than one year after the date the grant was made or the contract was entered into, as the case may be.

(d) An application for a grant or contract under this section shall—

(1) demonstrate to the satisfaction of the Secretary the need of the area for the emergency medical services system for which the application is made;

(2) contain assurances satisfactory to the Secretary that the applicant is qualified to plan an emergency medical services system for such area; and

(3) contain assurances satisfactory to the Secretary that the planning will be conducted in cooperation (A) with each section 1515 health systems agency whose health systems plan covers or will cover (in whole or in part) such area, and (B) with any emergency medical services council or other entity responsible for review and evaluation of the provision of emergency medical services in such area.

(e) The amount of any grant under this section shall be determined by the Secretary.

(f) The Secretary may not obligate or expend in any fiscal year for grants and contracts made or entered into under subsection (b)(1) an amount greater than 50 per centum of the sums appropriated in such year for grants and contracts made or entered into under this section.

GRANTS AND CONTRACTS FOR ESTABLISHING AN INITIAL OPERATION

42 U.S.C. 300d-2

SEC. 1203. (a) The Secretary may make grants to and enter into contracts with eligible entities (as defined in section 1206(a)) for the establishment and initial operation of emergency medical services systems.

(b) Special consideration shall be given to applications for grants and contracts for systems which will coordinate with statewide emergency medical services system.

(c)(1) Grants and contracts under this section may be used for the modernization of facilities for emergency medical services systems and other costs of establishment and initial operation.

(2) Each grant or contract under this section shall be made for costs of establishment and operation in the year for which the grant or contract is made. If a grant or contract is made under this section for a system, the Secretary may make one additional grant or contract for that system if he determines, after a review of the first at least nine months' activities of the applicant carried out under the first grant or contract, that the applicant is satisfactorily progressing in the establishment and operation of the system in accordance with the plan contained in its application (pursuant to section 1206(b)(4)) for the first grant or contract.

(3) No grant or contract may be made under this section for the fiscal year ending September 30, 1979, to an entity which did not receive a grant or contract under this section for the preceding fiscal year.

(4) Subject to section 1206(f)—

(A) the amount of the first grant or contract under this section for an emergency medical services

system may not exceed (i) 50 per centum of the establishment and operation costs (as determined pursuant to regulations of the Secretary) of the system for the year for which the grant or contract is made, or (ii) in the case of applications which demonstrate an exceptional need for financial assistance, 75 per centum of such costs for such year; and

(B) the amount of the second grant or contract under this section for a system may not exceed (i) 25 per centum of the establishment and operation costs (as determined pursuant to regulations of the Secretary) of the system for the year for which the grant or contract is made, or (ii) in the case of applications which demonstrate an exceptional need for financial assistance, 50 per centum of such costs for such year.

(5) In considering applications which demonstrate exceptional need for financial assistance, the Secretary shall give special consideration to applications submitted for emergency medical services systems for rural areas (as defined in regulations of the Secretary).

(d) A grant or contract may not be made to or entered into with an entity under this section with respect to an emergency medical services system unless the entity submits with its application for such grant or contract assurances of the participation in and support of the system by the public, private, and volunteer organizations and entities which are associated with and involved in activities essential to the effective provision of emergency medical services in the system's service area.

(e)(1) A first grant or contract may not be made to or entered into with an entity under this section with respect to an emergency medical services system unless the entity submits with its application for such grant or contract assurances, from the executive or legislative governmental bodies of political subdivisions located in the system's service area which govern a substantial proportion of the population residing in such area, of each such bodies' support of and cooperation with the system.

(2) A second grant or contract may not be made to or entered into with an entity under this section with respect to an emergency medical services system unless—

(A) the Secretary has made the required determination under subsection (c)(2);

(B) the application for such grant or contract includes specific plans for the step-by-step achievement of compliance with each of the requirements of section 1206(b)(4)(C) within the period specified in section 1206(b)(4)(B)(i); and

(C) the application for such grant or contract includes assurances, evidenced by copies of formal resolutions, proclamations, or other acts of the executive or legislative governmental bodies of political subdivisions located in the system's service area which govern a substantial proportion of the population residing in such area, of such bodies'—

(i) continued support and cooperation with the system, and

(ii) financial support of the system, in the year after the conclusion of the period of support under the grant or contract, sufficient to maintain the system at the level at which such system is to be maintained during the period of the grant or contract.

(f) An eligible entity which has received a grant from or has entered into a contract with the Secretary under this section shall submit to the Secretary and the Interagency Committee on Emergency Medical Services (established under section 1209) a report on the results of such grant or contract at such intervals as the Secretary may prescribe, and shall submit to the Secretary and such Committee a final report on the results of grants made to or contracts entered into with the entity under this section not later than one year after the completion of the second such grant or contract under this section.

GRANTS AND CONTRACTS FOR EXPANSION AND IMPROVEMENT

42 U.S.C. 300d-3

SEC. 1204. (a) The Secretary may make grants to and enter into contracts with eligible entities (as defined in section 1206(a)) for projects for the expansion and improvement of emergency medical services systems, including the acquisition of equipment and facilities, the modernization of facilities, and other projects to expand and improve such systems.

(b)(1) Each grant or contract for a project under this section shall be made for the project's costs of expansion and improvement in the year for which the grant or contract is made or entered into. If a grant or contract is made or entered into under this section for a system, the Secretary may make one additional grant or contract for that system if he determines, after a review of at least the first nine months' activities of the applicant carried out under the first grant or contract, that the applicant is satisfactorily progressing in the expansion and improvement of the system in accordance with the plan contained in its application (pursuant to section 1206(b)(4)) for the first grant or contract.

(2) Subject to section 1206(f)—

(A) the amount of the first grant or contract under this section for an emergency medical services system may not exceed (i) 50 per centum of the expansion and improvement costs (as determined pursuant to regulations of the Secretary) of the system for the year for which the grant or contract is made, or (ii) in the case of applications which demonstrate an

exceptional need for financial assistance, 75 per centum of such costs for such year; and

(B) the amount of the second grant or contract under this section for a system may not exceed (i) 25 per centum of the expansion and improvement costs (as determined pursuant to regulations of the Secretary) of the system for the year for which the grant or contract is made, or (ii) in the case of applications which demonstrate an exceptional need for financial assistance, 50 per centum of such costs for such year.

(c) A grant or contract may not be made to or entered into with an entity under this section with respect to an emergency medical services system unless the entity submits with its application for such grant or contract assurances of the participation and support of the system by the public, private, and volunteer organizations and entities which are associated with and involved in activities essential to the effective provision of emergency medical services in the system's service area.

(d)(1) A grant or contract may not be made to or entered into with an entity under this section with respect to an emergency medical services system unless—

(A) the application for such grant or contract includes specific plans for the step-by-step achievement of compliance with each of the requirements of section 1206(b)(4)(C) within the period specified in section 1206(b)(4)(B)(i); and

(B) the application for such grant or contract includes assurances, evidenced by copies of formal resolutions, proclamations, or other acts of the executive or legislative governmental bodies of political subdivisions located in the system's service area which govern a substantial proportion of the population residing in such area, of such bodies'—

(i) support and cooperation with the system, and

(ii) endorsement and support of a specific financial plan which provides for the maintenance of the financial support of the system, after the conclusion of the period of the grant or contract, at the level required to maintain the level of expanded or improved activity to be achieved during the period of the grant or contract.

(2) A second grant or contract may not be made to or entered into with an entity under this section with respect to an emergency medical services system unless—

(A) the Secretary has made the required determination under subsection (b)(1), and

(B) the application for such grant or contract includes assurances, of the executive or legislative governmental bodies of political subdivisions located in the system's service area which govern a substantial proportion of the population residing in such area, that substantial progress is being made toward achieving the financial support to implement the plan described in paragraph (1)(B)(ii).

(e) An eligible entity which has received a grant from or has entered into a contract with the Secretary under this section shall submit to the Secretary and the Interagency Committee on Emergency Medical Services (established under section 1209) a report on the results of such grant or contract at such intervals as the Secretary may prescribe, and shall submit to the Secretary and such Committee a final report on the results of grants made to or contracts entered into with the entity under this section not later than one year after the completion of the second such grant or contract under this section.

GRANTS AND CONTRACTS FOR RESEARCH

42 U.S.C. 300d–4

SEC. 1205. (a) The Secretary may make grants to and enter into contracts with public or private nonprofit entities, and enter into contracts with private entities and individuals, for the support of research in emergency medical techniques, methods, devices, and delivery. The Secretary shall give special consideration to applications for grants or contracts for research relating to the delivery of emergency medical services in rural areas and especially research which emphasizes the identification and utilization of techniques and methods to apply the results of such research to improve the delivery of emergency medical services in such areas.

(b) No grant may be made or contract entered into under this section for amounts in excess of $35,000 unless the application therefor has been recommended for approval by an appropriate peer review panel designated or established by the Secretary. Any application for a grant or contract under this section shall be submitted in such form and manner, and contain such information, as the Secretary shall prescribe in regulations.

(c) The recipient of a grant or contract under this section shall make such reports to the Secretary as the Secretary may require. Such reports shall contain recommendations and a plan of action for applying the results of the research assisted by such grant or contract to improve the delivery of emergency medical services.

(d)(1) Before any grant or contract may be made or entered into by the Secretary under this section the Secretary shall consult, concerning such grant or contract, with the identifiable administrative unit described in section 1208.

(2) No regulation, guideline, funding priority, or application form shall be established under this section without the full participation in the development of such regulation, guideline, priority, or form, by the identifiable administrative unit described in section 1208.

GENERAL PROVISIONS RESPECTING GRANTS AND CONTRACTS

SEC. 1206. (a) For purposes of sections 1202, 1203, and 1204, the term "eligible entity" means— 42 U.S.C. 300d-5

(1) a State,

(2) a unit of general local government,

(3) a public entity administering a compact or other regional arrangement or consortium, or

(4) any other public entity and any nonprofit private entity.

(b)(1)(A) No grant or contract may be made under this part unless an application therefor has been submitted to, and approved by, the Secretary.

(B) No applicant may receive more than a total of five years of grant or contract assistance under this part, except that, in determining the number of years of grant or contract assistance which an applicant received under this part, the Secretary shall not include any period during which the applicant received grant or contract assistance under section 1202(b)(1) of section 1205.

(2) In considering applications submitted under this title, the Secretary shall give priority to applications submitted by the entities described in clauses (1), (2), and (3) of subsection (a).

(3) No application for a grant or contract under section 1202 may be approved unless—

(A) the application meets the application requirements of such section;

(B) in the case of an application submitted by a public entity administering a compact or other regional arrangement or consortium, the compact or other regional arrangement or consortium includes each unit of general local government of each standard metropolitan statistical area (as determined by the Office of Management and Budget) located (in whole or in part) in the service area of the emergency medical services system for which the application is submitted;

(C) in the case of an application submitted by an entity described in clause (4) of subsection (a), such entity has provided a copy of its application to each entity described in clauses (1), (2), and (3) of such subsection which is located (in whole or in part) in the service area of the emergency medical services system for which the application is submitted and

has provided each such entity a reasonable opportunity to submit to the Secretary comments on the application;

(D) the—

(i) section 1521 State health planning and development agency of each State in which the service area of the emergency medical services system for which the application is submitted will be located, and

(ii) section 1515 health systems agency whose health systems plan covers or will cover (in whole or in part) the service area of such system,

have had not less than thirty days (measured from the date a copy of the application was submitted to the agency by the applicant) in which to comment on the application;

(E) the applicant agrees to maintain such records and make such reports to the Secretary as the Secretary determines are necessary to carry out the provisions of this title; and

(F) the application is submitted in such form and such manner and contains such information (including specification of applicable provisions of law or regulations which restrict the full utilization of the training and skills of health professions and allied and other health personnel in the provision of health care services in such a system) as the Secretary shall prescribe in regulations.

(4)(A) No application for a grant or contract under section 1203 or 1204 may be approved by the Secretary unless (i) the application meets the requirements of the respective section and of subparagraphs (B) through (F) of paragraph (3), and (ii) except as provided in subparagraph (B)(ii), the applicant (I) demonstrates to the satisfaction of the Secretary that the emergency medical services system for which the application is submitted will, within the period specified in subparagraph (B)(i), meet each of the emergency medical services system requirements specified in subparagraph (C), and (II) provides in the application a plan satisfactory to the Secretary for the system to meet each such requirement within such period.

(B)(i) The period within which an emergency medical services system must meet each of the requirements specified in subparagraph (C) is the total period of eligibility for assistance under the section for which the application for assistance is made; except that if the applicant demonstrates to the satisfaction of the Secretary the inability of the applicant's emergency medical services system to meet one or more of such requirements within such period, the period (or periods) within which the system must meet such requirement (or requirements) is such period (or periods) as the Secretary may require.

(ii) If an applicant submits an application for a grant or contract under section 1203 or 1204 and demonstrates to the satisfaction of the Secretary the inability of the system for which the application is submitted to meet one or more of the requirements specified in subparagraph (C) within any specific period of time, the demonstration and plan prerequisites prescribed by clause (ii) of subparagraph (A) shall not apply with respect to such requirement (or requirements) and the applicant shall provide in his application a plan, satisfactory to the Secretary, for achieving appropriate alternatives to such requirement (or requirements).

(C) An emergency medical services system shall—

(i) include an adequate number of health professions, allied health professions, and other health personnel with appropriate training and experience;

(ii) provide for its personnel appropriate training (including clinical training) and continuing education programs which (I) are coordinated with other programs in the system's service area which provide similar training and education, and (II) emphasize recruitment and necessary training of veterans of the Armed Forces with military training and experience in health care fields and of appropriate public safety personnel in such area;

(iii) join the personnel, facilities, and equipment of the system by a central communications system so that requests for emergency health care services will be handled by a communications facility which (I) utilizes emergency medical telephonic screening, (II) utilizes or, within such period as the Secretary prescribes will utilize, the universal emergency telephone number 911, (III) will have direct communication connections and interconnections with the personnel, facilities, and equipment of the system and with other appropriate emergency medical services systems, (IV) will have the capability to communicate with individuals having auditory handicaps and to communicate in the language of the predominant population groups with limited English-speaking ability in the system's service area, and (V) makes maximum use of communications equipment and systems acquired under any highway safety program approved under chapter 4 of title 23, United States Code, and of such equipment and system acquired under title I of the Omnibus Crime Control and Safe Streets Act of 1968 (42 U.S.C. 3701 et seq.);

(iv) include (making maximum use of vehicles acquired under any highway safety program approved under chapter 4 of title 23, United States Code) an adequate number of necessary ground, air, and water vehicles and other transportation facilities

to meet the individual characteristics of the system's service area—

(I) which vehicles and facilities meet appropriate standards relating to location, design, performance, and equipment, and

(II) the operators and other personnel for which vehicles and facilities meet appropriate training and experience requirements;

(v) include an adequate number of easily accessible emergency medical services facilities which are collectively capable of providing services on a continuous basis, which have appropriate nonduplicative and categorized capabilities, which meet appropriate standards relating to capacity, location, personnel, and equipment, and which are coordinated with other health care facilities of the system;

(vi) provide access (including appropriate transportation) to specialized critical medical care units in the system's service area, or, if there are no such units or an inadequate number of them in such area, provide access to such units in neighboring areas if access to such units is feasible in terms of time and distance;

(vii) provide for the effective utilization of the appropriate personnel, facilities, and equipment of each public safety agency providing emergency services in the system's service area;

(viii) be organized in a manner that provides persons who reside in the system's service area and who have no professional training or financial interest in the provision of health care with an adequate opportunity to participate in the making of policy for the system;

(ix) provide, without prior inquiry as to ability to pay, necessary emergency medical services to all patients requiring such services;

(x) provide for transfer of patients to facilities and programs which offer such followup care and rehabilitation as is necessary to effect the maximum recovery of the patient;

(xi) provide for a coordinated patient record-keeping system meeting appropriate standards established by the Secretary, which records shall cover the treatment of the patient from initial entry into the system through his discharge from it, and shall be consistent with ensuing patient records used in followup care and rehabilitation of the patient;

(xii) provide programs of public education and information in the system's service area (taking into account the needs of visitors to, as well as residents of, that area to know or be able to learn immediately the means of obtaining emergency medical services) which programs stress the general dissemination of

information regarding appropriate methods of medical self-help and first-aid and regarding the availability of first-aid training programs in the area;

(xiii) provide the Secretary with such information as he may require to conduct periodic, comprehensive, and independent reviews and evaluations of the extent and quality of the emergency health care services provided in the system's service area, and submit to the Secretary the results of any review or evaluation which may be conducted by such system of the extent and quality of the emergency health care services provided in the system's service area;

(xiv) have a plan to assure that the system will be capable of providing emergency medical services in the system's service area during mass casualties, natural disasters, or national emergencies; and

(xv) provide for the establishment of appropriate arrangements with emergency medical services systems or similar entities serving neighboring areas for the provision of emergency medical services on a reciprocal basis where access to such services would be more appropriate and effective in terms of the services available, time, and distance.

The Secretary shall by regulations prescribe standards and criteria for the requirements prescribed by this subparagraph. In prescribing such standards and criteria, the Secretary shall consider relevant standards and criteria prescribed by other public agencies and by private organizations.

(5) The Secretary shall provide technical assistance, as appropriate, to eligible entities as necessary for the purpose of their preparing applications or otherwise qualifying for or carrying out grants or contracts under sections 1202, 1203, or 1204, with special consideration for applicants in rural areas.

(c) Payments under grants and contracts under this title may be made in advance or by way of reimbursement and in such installments and on such conditions as the Secretary determines will most effectively carry out this title.

(d) Contracts may be entered into under this title without regard to sections 3648 and 3709 of the Revised Statutes (31 U.S.C. 529; 41 U.S.C. 5).

(e) No funds appropriated under any provision of this Act other than section 301, title IV, title VII, section 1207, or section 1221 may be used to make a new grant or contract in any fiscal year for a purpose for which a grant or contract is authorized by this part unless (1) all the funds authorized to be appropriated by section 1207(a) for such fiscal year have been appropriated and made available for obligation in such fiscal year, and (2) such new grant or contract is made in accordance

with the requirements of this part that would be applicable to such grant or contract if it was made under this part. For purposes of this subsection, the term "new grant or contract" means a grant or contract for a program or project for which an application was first submitted after the date of the enactment of the Act which makes the first appropriations under the authorizations contained in section 1207.

(f)(1) In determining the amount of any grant or contract under section 1203 or 1204, the Secretary shall take into consideration the amount of funds available to the applicant from Federal grant or contract programs under laws other than this Act for any activity which the applicant proposes to undertake in connection with the establishment and operation or expansion and improvement of an emergency medical services system and for which the Secretary may authorize the use of funds under a grant or contract under sections 1203 and 1204.

(2) The Secretary may not authorize the recipient of a grant or contract under section 1203 or 1204 to use funds under such grant or contract for any training program (other than basic training of emergency medical technicians, training of paramedics, and short-term specialized training or retraining of physicians, nurses, and other health care professionals) in connection with an emergency medical services system unless the applicant (A) has filed an application (as appropriate) under title VII or VIII for a grant or contract for such program and such application was not approved or was approved but for which no or inadequate funds were made available under such title, or (B) has demonstrated to the satisfaction of the Secretary that the filing of such an application would be futile or unreasonably burdensome.

AUTHORIZATION OF APPROPRIATIONS

42 U.S.C. 300d-6

SEC. 1207. (a)(1) For the purpose of making payments pursuant to grants and contracts under sections 1202, 1203, and 1204, there are authorized to be appropriated $30,000,000 for the fiscal year ending June 30, 1974, $60,000,000 for the fiscal year ending June 30, 1975, $35,000,000 for the fiscal year ending June 30, 1976, $5,083,000 for the period beginning July 1, 1976, and ending September 30, 1976, $45,000,000 for the fiscal year ending September 30, 1977, and $55,000,000 for the fiscal year ending September 30, 1978; and for the purpose of making payments pursuant to grants and contracts under sections 1203 and 1204, there are authorized to be appropriated $70,000,000 for the fiscal year ending September 30, 1979.

(2) Of the sums appropriated under paragraph (1) for any fiscal year, not less than 20 per centum shall be

made available for grants and contracts under this title for such fiscal year for emergency medical services systems which serve or will serve rural areas (as defined in regulations of the Secretary under section 1203(c)(5)).

(3) Of the sums appropriated under paragraph (1) for the fiscal year ending June 30, 1974, or the succeeding fiscal year—

(A) 15 per centum of such sums for each such fiscal year shall be made available only for grants and contracts under section 1202 (relating to feasibility studies and planning) for such fiscal year;

(B) 60 per centum of such sums for each such fiscal year shall be made available only for grants and contracts under section 1203 (relating to establishment and initial operation) for such fiscal year; and

(C) 25 per centum of such sums for each such fiscal year shall be made available only for grants and contracts under section 1204 (relating to expansion and improvement) for such fiscal year.

(4) Of the sums appropriated under paragraph (1) for the fiscal year ending June 30, 1976—

(A) 75 per centum of such sums shall be made available only for grants and contracts under section 1203 for such fiscal year, and

(B) 25 per centum of such sums shall be made available only for grants and contracts under section 1204 for such fiscal year.

(5)(A) Of the sums appropriated under paragraph (1) for the fiscal year ending September 30, 1977, and for the succeeding fiscal year, at least 2½ per centum but not more than 5 per centum of such sums for each such fiscal year shall be used for grants and contracts under section 1202.

(B) Of the sums appropriated under paragraph (1) for the fiscal year ending September 30, 1977, and for each of the two succeeding fiscal years, (i) not less than 20 per centum of such sums for each such fiscal years shall be used for grants and contracts under section 1203, and (ii) not less than 20 per centum of such sums for each such fiscal year shall be used for grants and contracts under section 1204.

(b) For the purpose of making payments pursuant to grants and contracts under section 1205 (relating to research), there are authorized to be appropriated $5,000,000 for the fiscal year ending June 30, 1974, and for each of the next five fiscal years.

ADMINISTRATION

SEC. 1208. (a) The Secretary shall administer the program of grants and contracts (except for grants and contracts under section 1205) authorized by this part through an identifiable administrative unit specializing in emergency medical services within the Department of Health, Education, and Welfare. 42 U.S.C. 300d-7

(b) Such administrative unit shall—

(1) be responsible for collecting, analyzing, cataloging, and disseminating all data useful in the development and operation of emergency medical services systems, including data derived from reviews and evaluations of emergency medical services systems assisted under sections 1202, 1203, and 1204;

(2) publish suggested criteria for collecting necessary information for the evaluation of projects and programs funded under this title;

(3) participate fully in the development of regulations, guidelines, funding priorities, and application forms relating to activities carried out under sections 776, 1205, and 1221;

(4) be consulted in advance of the awarding of grants and contracts under section 776, 1205, and 1221;

(5) be consulted in advance of the issuance of regulations, guidelines, and funding priorities relating to research or training in the area of emergency medical services carried out under any other authority of this Act;

(6) provide technical assistance (with special consideration for applicants in rural areas) and monitoring with respect to grant and contract activities under sections 1202, 1203, 1204, and 1221; and

(7) provide for periodic, independent evaluations of the effectiveness of, and coordination between, the programs carried out under this part and the programs carried out under sections 776 and 1221.

(c) In addition, such administrative unit shall, through the Interagency Committee on Emergency Medical Services (established under section 1209)—

(1) study on a continuing basis (including evaluating the adequacy, technical soundness, and redundancy of) the roles, resources, and responsibilities of all Federal programs and activities relating to emergency medical services;

(2) annually update (A) the Federal emergency medical services funding and resource-sharing plan, (B) the description of sources of Federal support, and (C) the recommended uniform standards with respect to emergency medical services equipment and training, all initially developed and published by the Committee under section 1209(b);

(3) make recommendations to the Secretary respecting steps he might take, using the authorities available to him, to encourage States to implement the recommended uniform standards described in paragraph (2)(C); and

(4) make recommendations to the Secretary respecting the administration of, and regulations under, the programs of grants and contracts under this title.

Such unit shall report to the Congress the results of studies made under paragraph (1). The first such report shall be made not later than June 15, 1977, the second such report shall be made not later than February 1, 1978, and subsequent reports shall be made not later than February 1 of each year after 1978.

INTERAGENCY COMMITTEE ON EMERGENCY MEDICAL SERVICES

SEC. 1209. (a) The Secretary shall establish an Interagency Committee on Emergency Medical Services. The Committee shall coordinate and provide for the communication and exchange of information among all Federal programs and activities relating to emergency medical services, and shall carry out its responsibilities under section 1208(c). 42 U.S.C. 300d-8

(b) The Committee shall, not later than July 1, 1977, develop and publish:

(1) A coordinated, comprehensive Federal emergency medical services funding and resource-sharing plan, designed to promote the coordination between, and enhance the effectiveness of, Federal, State, and local funding and operation of programs and agencies relating to emergency medical services and related activities (including communication and transportation systems of public safety agencies).

(2) A description of sources of Federal support for the purchase of vehicles and communications equipment and for training activities related to emergency medical services.

(3) Recommended uniform standards of quality, health, and safety with respect to all equipment (including communications and transportation equipment) and training related to emergency medical services.

The plan described in paragraph (1) shall include a report containing recommendations for any legislation which would enhance the capability of Federal, State, and local governments to provide an integrated response in medical emergencies. The description described in paragraph (2) shall be disseminated to the regional offices of Federal agencies which provide financial support in the purchase of vehicles and equipment or in training activities related to emergency medical services for distribution to appropriate entities and the public.

(c) The Secretary or his designee shall serve as Chairman of the Committee, the membership of which shall include (1) appropriate scientific, medical, or technical representation from the Department of Transportation,

the Department of Justice, the Department of Defense, the Veterans' Administration, the National Science Foundation, the Federal Communications Commission, and such other Federal agencies and offices (including appropriate agencies and offices of the Department of Health, Education, and Welfare) and from the National Academy of Sciences, as the Secretary determines administer programs directly affecting the functions or responsibilities of emergency medical services systems, and (2) five individuals from the general public appointed by the President from individuals who by virtue of their training or experience are particularly qualified to participate in the performance of the Committee's functions. The Committee shall meet at the call of the Chairman, but not less often than four times a year.

(d) Each appointed member of the Committee shall be appointed for a term of four years, except that—

(1) any member appointed to fill a vacancy occurring prior to the expiration of the term for which his predecessor was appointed shall be appointed for the remainder of such term; and

(2) of the members first appointed, two shall be appointed for a term of four years, two shall be appointed for a term of three years, and one shall be appointed for a term of one year, as designated by the President at the time of appointment.

Appointed members may serve after the expiration of their terms until their successors have taken office.

(e) Appointed members of the Committee shall receive for each day they are engaged in the performance of the functions of the Committee compensation at rates not to exceed the daily equivalent of the annual rate in effect for grade GS-18 of the General Schedule, including traveltime; and all members, while so serving away from their homes or regular places of business, may be allowed travel expenses, including per diem in lieu of subsistence, in the same manner as such expenses are authorized by section 5703 of title 5, United States Code, for persons in the Government service employed intermittently.

(f) The Secretary shall make available to the Committee such staff, information (including copies of reports of reviews and evaluations of emergency medical services systems assisted under section 1202, 1203, or 1204), and other assistance as it may require to carry out its activities effectively.

ANNUAL REPORT

SEC. 1210. The Secretary shall prepare and submit annually to the Congress a report on the administration of this title. Each report shall include an evaluation of the adequacy of the provision of emergency medical services in the United States during the period covered by the 42 U.S.C. 300d-9

report, and evaluation of the extent to which the needs for such services are being adequately met through assistance provided under this title, and his recommendations for such legislation as he determines is required to provide emergency medical services at a level adequate to meet such needs. The first report under this section shall be submitted not later than September 30, 1974, and shall cover the fiscal year ending June 30, 1974. The report under this section covering the fiscal year ending June 30, 1976, shall also cover the period beginning July 1, 1976, and ending September 30, 1976, and shall be submitted to Congress not later than February 1, 1977. The report under this section covering the fiscal year ending September 30, 1977, and each report covering each subsequent fiscal year, shall be submitted to Congress not later than February 1, in the fiscal year following each such fiscal year.

PART B—BURN INJURIES

PROGRAMS RELATING TO BURN INJURIES

SEC. 1221. (a)(1) The Secretary may make grants to, and enter into contracts with, public or private nonprofit entities for the support of, and may conduct, programs for the establishment, operation, and improvement of activities to (A) demonstrate the effectiveness of different methods for the treatment and rehabilitation of individuals injured by burns, (B) conduct research in the treatment and rehabilitation of such individuals, and (C) provide training in such treatment and rehabilitation and in such research. 42 U.S.C. 300d-21

(2) The Secretary may enter into contracts with entities and individuals for the support of research in the treatment and rehabilitation of individuals injured by burns.

(b) No grant or contract may be made or entered into under subsection (a) unless an application therefor has been submitted to, and approved by, the Secretary. Such application shall be submitted in such form and manner and contain such information as the Secretary may require. In considering applications under this section, the Secretary shall give priority to applications for programs which (1) will provide services within a geographical area in which services are not currently being adequately provided, and (2) are in or accessible to the service area of an emergency medical services system (as defined in section 1201(1)).

(c) For purposes of carrying out subsection (a), there are authorized to be appropriated $5,000,000 for the fiscal year ending September 30, 1977, $7,500,000 for the fiscal year ending September 30, 1978, and $10,000,000 for the fiscal year ending September 30, 1979.

December 1978

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EMERGENCY HEALTH SERVICES IN A NUCLEAR ATTACK ENVIRONMENT

SYSTEM SCIENCES, INC. Contract No. DCPA-01-78-C-0210
4340 East-West Highway Work Unit 2422G
Bethesda, Maryland 20014 May 1979
168 Pages

ABSTRACT

This project addresses the issues surrounding the preparedness status of the United States to cope with the <u>health</u> and medical <u>care</u> requirements in the event of a nuclear attack.

To assess the current status of National preparedness,

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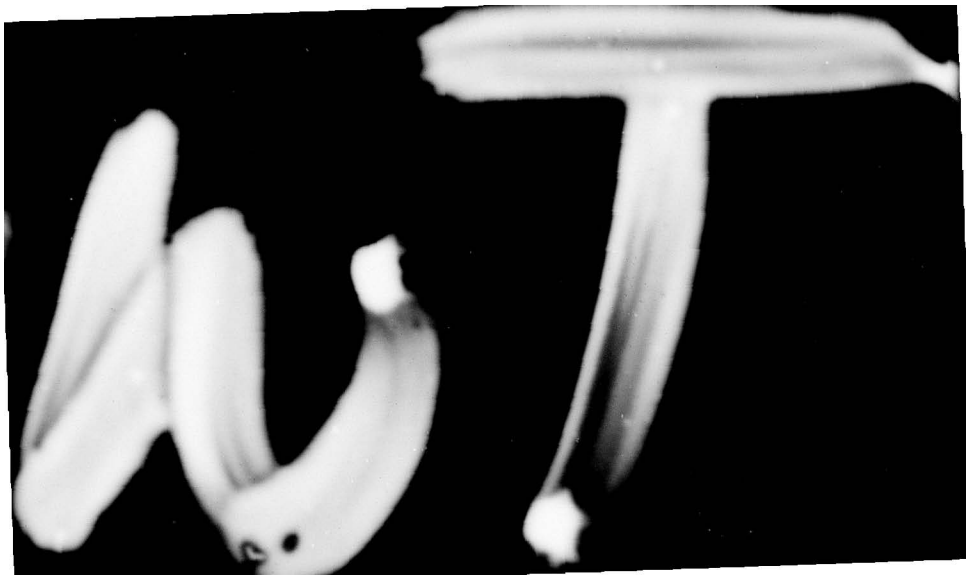

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Any pages missing in the document or Appendix A and B are not available per the originator. (per Ms. Foxvog).

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